SUMMARY OF AND RESPONSE TO PUBLIC COMMENT RECEIVED PRIOR TO SEPTEMBER 13, 2006, PUBLIC COMMENT DEADLINE

Introductory, Concluding, and/or General Remarks Not Specific to a Particular Section

Commentor: Sherman Sitrin, on behalf of American International Group (AIG), September 12, 2006, Cover page;
Mary B. Gaillard, on behalf of AIG, page 1;
Oral statements by Sherman Sitrin and Mary Gaillard, AIG, September 13, 2006, transcript pages 36-37.

Summary: Introductory comments.

Response: Because this portion of the comment is not specifically directed at the Commissioner's proposed revised regulations or to the procedures followed in proposing the revised regulations, no response is necessary. To the extent the comment generally describes the focus of the comments, a detailed response is provided below in connection with the summary of and response to the more detailed comment.

Commentor: Mary B. Gaillard, on behalf of AIG, September 12, 2006, page 1;
William K. Johanneson, on behalf of Farmers Insurance Group, September 13, 2006, page 2.

Summary: "One-size-fits-all" and non-pliable methods have the potential to result in the unfair treatment of insurers. In turn, this treatment creates a disincentive for insurers to compete to provide the best possible products to consumers.

Response: The "one-size-fits-all" argument was rejected by the California Supreme Court in *20th Century*. Indeed, both the *Calfarm* and *20th Century* courts made it clear that the Commissioner has the legal authority to take those steps reasonably necessary to make the job of rate regulation manageable. (*20th Century, (*quoting *Calfarm)* 8 Cal. 4th 216, 245; 32 Cal. Rptr. 807, 824.) With that said, the regulation is replete with revisions, as is explained in detail herein, allowing for the application of company-specific data. And, as is also explained in detail herein, various constitutional safety-valves, known as variances, have been revised or added to the regulations to increase flexibility. All told, what detractors have referred to as the "cookie-cutter" characteristic of the regulations has been addressed.

Commentor: Mary B. Gaillard, on behalf of AIG, September 12, 2006, Page 1; oral statement of Mary Gaillard (AIG), transcript, pages 37-38;
William K. Johanneson, on behalf of Farmers Insurance Group, September 13, 2006, page 2.

Summary: The use of industry averages and one ratemaking methodology for all lines of business seems to contradict the Casualty Actuarial Society's "Statement of Principles

Regarding Property and Casualty Insurance Ratemaking" and is not reasonable. No single ratemaking methodology is appropriate in all cases. Actuarial judgment is eliminated.

Response: The regulations do not set forth one ratemaking methodology for all lines of business. In numerous areas, the regulations treat the various components of the various lines of insurance differently. The regulations do not require insurers to calculate the rates using the methodology employed in the regulations. However, the regulations will be used to review the rates calculated by an insurer to determine whether the rates fall into the zone of reasonableness, that is, the range between excessive and inadequate. While the regulations may require specifics as to how data is to be reported, the regulations do not require insurers to employ a specific ratemaking methodology and do not impede an insurer's exercise of actuarial judgment.

The ratemaking formula is designed to, and does, yield a premium that the insurer should receive from its insureds in order to earn a sum amounting to (1) the reasonable cost of providing insurance and (2) the capital used and useful for providing insurance multiplied by a fair rate of return. This is consistent with the general rule that the rate set for a regulated firm is the sum of (1) its cost of service and (2) its capital base multiplied by a rate of return. Indeed, the regulations are designed to and do result in rates that are neither excessive, inadequate nor unfairly discriminatory and in keeping with sound actuarial and legal principles *before the* application of the variances, which are safety-valves providing a second layer of protection from confiscation.

For many years the regulations have been subject to the criticism that, "No single ratemaking methodology is appropriate in all cases." The regulations are replete with exceptions for various lines in myriad circumstances. The Commissioner is required by law to allow insurers a rate that is not confiscatory and these regulations are designed to meet that requirement. The fact that the regulations employ a ratemaking formula is neither new, nor novel, nor offensive to the actuarial principles, as the *20th Century* Court pointed out in upholding the current regulations.

The court noted that it is "the result reached not the method employed which is controlling." (*Power Comm'n v. Hope Gas Company, 320 U.S. at p. 602 [88 L.Ed. at p. 345].)* Indeed, the method may be novel (see *Duquesne Light Company v. Barasch, 488 U.S. at p. 316 [102 L.Ed.2d at p. 662])* and implicate formulaic ratemaking (see *Permian Basin Area Rate Cases, 390 U.S. at pp. 768-770 [20 L.Ed.2d at pp. 336-338])* using data reflecting the condition and performance of a group of regulated firms (see *id. at pp. 766-790 [20 L.Ed.2d at pp. 335-349]).*

Commentor: Peter Cazzolla , on behalf of Capital Insurance Group (CIG), September 12, 2006; page 1; oral statement of Peter Cazzolla (CIG); transcript pages 14-15.

Summary: Introductory comments.

Response: Because this portion of the comment is not specifically directed at the Commissioner's proposed revised regulations or to the procedures followed in proposing the revised regulations, no response is necessary. To the extent the comment generally describes the focus of the comments, a detailed response is provided below in connection with the summary of and response to the more detailed comment.

Commentor: Peter Cazzolla , on behalf of Capital Insurance Group, September 12, 2006; page 1.

Summary: The current rate approval regulations are working reasonably effectively between our actuaries and the CDI rate analysts. The one area that continues to need improvement is the speed of the rate-approval process, and a streamlining of this process would be a tremendous boost to getting rate changes and products to market more quickly, benefiting consumers and companies with timely and fair rates.

Response: The Commissioner agrees with this comment to the extent it pertains to the proposed regulations. The regulations as proposed reflect a system that evolved over time and has been reasonably successful. The changes in these proposed regulations result from experience gained in years of case-by-case determinations and in response to comments and suggestion made by interested members of the public in the review of rate applications and during this rulemaking and/or in the previous workshops. The regulations are also designed to streamline the rate review process as they eliminate much of the guesswork for insurers by "codifying" the methodologies the Commissioner will employ to review rates.

Further streamlining of the process, as in additional personnel, technical innovations or the like, is outside the purview of these regulations.

Commentor: Alexis K. Wodtke, on behalf of Consumer Federation of California (CFC); September 13, 2006; page 1.

Summary: Introductory comments

Response: Because this portion of the comment is not specifically directed at the Commissioner's proposed revised regulations or to the procedures followed in proposing the revised regulations, no response is necessary. To the extent the comment generally describes the focus of the comments, a detailed response is provided below in connection with the summary of and response to the more detailed comment.

Commentor: William K. Johanneson, on behalf of Farmers Insurance Group, September 13, 2006, page 1.

Summary: Introductory comments.

Response: Because this portion of the comment is not specifically directed at the Commissioner's proposed revised regulations or to the procedures followed in proposing

the revised regulations, no response is necessary. To the extent the comment generally describes the focus of the comments, a detailed response is provided below in connection with the summary of and response to the more detailed comment.

Commentor: William K. Johanneson, on behalf of Farmers Insurance Group, September 13, 2006, pages 1, 9.

Summary: These regulations fail the requirements that regulations must be authorized, necessary, consistent and clear. They are not necessary to implement CIC § 1861.05(a) and to make the prior approval process work under Proposition 103.

Response: The comments regarding the Government Code standards for the adoption of regulations are addressed elsewhere in this rulemaking file. However, the Commissioner notes here that these regulations are subject to the ratemaking exception.

The Commissioner has determined that these regulations, the ratemaking formula, the use of industry average and a formulaic approach is what is *necessary and required* to keep the job of rate regulation in California manageable.

As set forth by the *20th Century* court: "Much is necessarily left to the Insurance Commissioner, who has broad discretion to adopt rules and regulations as necessary to promote the public welfare. . . [and] there is nothing here which prevents the commissioner from taking whatever steps are necessary to reduce the job to manageable size." " *20th Century,* 8 Cal. 4th 216, 309; 32 Cal. Rptr. 807, 824, 245.

The Commissioner has determined that the proposed rate regulations are valid as necessary and proper for the implementation of Proposition 103's rate regulation requirements. The public is entitled to know how the Commissioner will implement the rate approval provisions of Proposition 103, and to know the standards by which rate applications will be reviewed.

Commentor: Pamela Pressley, on behalf of the Foundation for Taxpayer and Consumer Rights (FTCR); September 13, 2006; page 1, oral statement of Pamela Pressley (FTCR), September 13, 2006, transcript page 41;
Oral statement of Allan Schwartz (FTCR), September 13, 2006, transcript pages 46-47.

Summary: Introductory comments.

Response: Because this portion of the comment is not specifically directed at the Commissioner's proposed revised regulations or to the procedures followed in proposing the revised regulations, no response is necessary. To the extent the comment generally describes the focus of the comments, a detailed response is provided below in connection with the summary of and response to the more detailed comment.

Commentor: Pamela Pressley, on behalf of the Foundation for Taxpayer and Consumer Rights (FTCR); September 13, 2006, page 1,
Oral statement of Allan I. Schwartz (FTCR), September 13, 2006, transcript pages 47-48.

Summary: FTCR endorses the amendments to the regulations that "closed the loopholes" by setting forth the specific parameters and methodologies for the previously undefined generic factors. FTCR continues to support the Department's efforts to ensure that the prior approval process is subject to clear and uniform standards that properly and fairly implement Proposition 103's mandate that rates not be "excessive, inadequate or unfairly discriminatory."

Response: As the comment is in accord with the proposed regulations, no response is required.

Commentor: Randall Farwell, on behalf of the Interinsurance Exchange of the Automobile Club; September 13, 2006; page 1.

Summary: Based on comments made by the Department staff during the workshops, it appears that the Department wishes to create a more transparent filing review process with consistency being an overriding concern. The regulations do not take into account the unique qualities associated with each line of business and each insurance carrier. That should be considered.

Response: While the Commissioner recognizes the differences in various product lines, the Commissioner disagrees that the regulations do not address these differences. The regulations contain "exceptions" for various lines in myriad circumstances and several new variances have been added to the regulations. The Commissioner is required by law to allow insurers a rate that is not confiscatory and these regulations are designed to meet that requirement. The fact that the regulations employ a ratemaking formula is not new nor is it novel, and the *20th Century* court upheld application of a formulaic approach.

Indeed, as the Court stated in *20th Century*:

One of the purposes of Proposition 103 is "to protect consumers from arbitrary insurance rates . . . . Formulaic ratemaking furthers that goal. Case-by-case ratemaking does the opposite. (Cf. 1 Davis & Pierce, Administrative Law Treatise (3d ed. 1994) § 6.7, p. 261 ["Over the years, commentators, judges, and Justices have shown near unanimity in extolling the virtues of the rulemaking process over the process of making 'rules' through case-by-case adjudication."].) There is, without doubt, nothing novel in the use of formulas of all sorts. (Cf., e.g., *Cal. Code Regs., tit. 22, § 51536* et seq. [setting rates for reimbursement for hospital inpatient services provided to Medi-Cal program beneficiaries]; see especially *id*., § 51549 [establishing a "reimbursement formula"].)

20th Century, 8 Cal. 4th 216, 285; 32 Cal. Rptr. 807, 851.

Commentor: Randall Farwell, on behalf of the Interinsurance Exchange of the Automobile Club; September 13, 2006; page 1.

Summary: While insurance may be a commodity, there are variations in the product, how it is marketed and how it is serviced, and regulations that do not allow insurers to offer different choices to consumers do a disservice to consumers.

Response: The Commissioner disagrees that these regulations do not allow insurers to offer different choices to consumers. The regulatory scheme set forth in these regulations has been utilized by the Department for more than ten years and no impact on the product offering has been discerned. Indeed, there are more insurance products on the market today in California than at any time in the past.

Commentor: Randall Farwell, on behalf of the Interinsurance Exchange of the Automobile Club; September 13, 2006; page 1.

Summary: The regulations are too rigid. In addition, rigid regulations will not allow either carriers or the Department to respond to changing conditions that could have a material impact on rate indications.

Response: As to rigidity, the insurance industry complaints relating to the rigidity of the regulations were rejected in *20th Century*. As to changes in market condition nothing in the regulation prevents an insurer from making a rate filing where such market conditions create a situation where a rate filing is required. The regulations are designed to reflect changing conditions. The comment is rejected.

Commentor: Milo Pearson and Christian Rataj, on behalf of the Pacific Association of Domestic Insurance Companies (PADIC) /National Association of Mutual Insurance Companies (NAMIC); September 12, 2006; pages 1-2.

Summary: General introductory comments.

Response: Because this portion of the comment is not specifically directed at the Commissioner's proposed revised regulations or to the procedures followed in proposing the revised regulations, no response is necessary. To the extent the comment generally describes the focus of the comments, a detailed response is provided below in connection with the summary of and response to the more detailed comment.

Commentor: Milo Pearson and Christian Rataj, on behalf of the Pacific Association of Domestic Insurance Companies (PADIC) /National Association of Mutual Insurance Companies (NAMIC); September 12, 2006; page 2.

Summary: The regulations will have an adverse impact on availability and affordability of insurance for consumers. Regulations that constrain insurance carriers' freedom to make individualized pricing and rating decisions are likely to limit their

ability to distinguish themselves from their competitors and offer rates and service that promote affordability and availability of insurance for consumers.

Response: As has been stated previously, in general, the regulatory scheme set forth in this rulemaking has been in utilized for many years, having evolved since the early 1990's. None of the "adverse impacts" described in the comment have occurred. The regulations place no limitation on insurers' ability to price their products competitively. Indeed, like Proposition 103 itself, the regulations are designed to "promote affordability and availability of insurance for consumers." For these reasons the comment is rejected.

Commentor: Milo Pearson and Christian Rataj, on behalf of the Pacific Association of Domestic Insurance Companies (PADIC) /National Association of Mutual Insurance Companies (NAMIC); September 12, 2006; page 2.

Summary: The regulations could have a negative impact upon market competition in the state. The regulations could discourage insurers from developing and marketing new insurance products.

Response: The comment is speculative and does not detail how the regulations could negatively impact market products and competition. In general, the regulatory scheme set forth in this rulemaking has been in utilized for many years, having evolved since the early 1990's. The Commissioner is aware of no adverse impact upon market competition or the development and marketing of new insurance products as a result of the regulations.

Commentor: Milo Pearson and Christian Rataj, on behalf of the Pacific Association of Domestic Insurance Companies (PADIC) /National Association of Mutual Insurance Companies (NAMIC); September 12, 2006; page 5.

Summary: There have been a number of positive changes to these regulations, particularly those that allow for the use of individual company experience rather than a generic number.

Response: As the comment is in accord with the proposed regulations, no response required.

Commentor: Milo Pearson and Christian Rataj, on behalf of the Pacific Association of Domestic Insurance Companies (PADIC) /National Association of Mutual Insurance Companies (NAMIC); September 12, 2006; pages 1-2;

David Appel on behalf of The Pacific Association of Domestic Insurance Companies/National Association of Mutual Insurance Companies; September 12, 2006; page 2-3;

Oral statement by Milo Pearson (on behalf of PADIC), September 13, 2006, transcript pages 5-9;

Oral statement by Peter Bang (on behalf of PADIC), September 13, 2006, transcript pages 9-10.

Summary: Introductory comments.

Response: Because this portion of the comment is not specifically directed at the Commissioner's proposed revised regulations or to the procedures followed in proposing the revised regulations, no response is necessary. To the extent the comment generally describes the focus of the comments, a detailed response is provided below in connection with the summary of and response to the more detailed comment.

Commentor: Pacific Association of Domestic Insurance Companies/National Association of Mutual Insurance Companies;
David Appel on behalf of The Pacific Association of Domestic Insurance Companies/National Association of Mutual Insurance Companies; September 12, 2006; pages 3-5.

Summary: The sections of the proposed regulations relying upon industry averages to set allowable values are inappropriately imposed on the broad cross-section of insurers operating in California, particularly smaller insurer that may be operating in a limited number of states and/or lines of business. That is because smaller insurers cannot achieve the benefits of diversification that accrue to larger firms, may be unable to recognize full economies of scale and scope in providing insurance services, and may therefore require higher than average expense provisions in their rates.

Response: As to the limited use of industry averages in the proposed regulation, it is true that the regulations do employ certain industry averages as incorporated into a detailed formula designed to ensure manageability and consistent treatment of insurers and insureds. At the same time, the regulations incorporate multiple company-specific factors. The company-specific factors allow for further tailoring of the rate to a particular company's situation. With that said, the Commissioner has determined that the regulations, specifically as they employ industry averages, are necessary and proper for the implementation of Proposition 103.

As to the regulations unfairly impacting smaller insurers, there has been no compelling demonstration of pronounced scale efficiencies in the insurance industry. While there are some large companies that are efficient, some are not and over the years numerous small companies have been shown to be highly efficient. As to benefits of diversification, variances are available to address these concerns.

Commentor: Kent R. Keller, Roxani M. Gillespie, Robert J. Cerny, Barger & Wollen, on behalf of 21st Century Insurance Company; September 13, 2006; pages 1-2.

Summary: The regulations would implement a rigid, formulaic system of rate review that will suppress innovation, punish specialized and smaller carriers, and deter insurers – and especially those that are publicly traded – from writing insurance in this state. CDI should replace the regulations with a more flexible system that promotes competition and consumer choice.

Response: The comment is speculative. For reasons already stated herein the Commissioner rejects the "too rigid" argument. There has been no evidence of a suppression of innovation in the insurance industry in California since the implementation of the current regulations. Concerns relating to publicly traded insurers not wanting to write insurance are discussed in detail elsewhere in this rulemaking file. The Commissioner has determined that the regulations strike an equitable balance between formulaic ratemaking and flexibility such that the job of rate regulation is manageable, consistent treatment is ensured, and the regulations provide ample protections for both insurers and insureds.

Commentor: Michael J. D'Arelli, on behalf of Western Insurance Agents Association; September 13, 2006; page 1.

Summary: Introductory and comments about the association.

Response: Because this portion of the comment is not specifically directed at the Commissioner's proposed revised regulations or to the procedures followed in proposing the revised regulations, no response is necessary. To the extent the comment generally describes the focus of the comments, a detailed response is provided below in connection with the summary of and response to the more detailed comment.

Commentor: Michael J. D'Arelli, on behalf of Western Insurance Agents Association; September 13, 2006; pages 1-2.

Summary: The propose regulations establish a one-size-fits-all approach to ratemaking, prohibit costs and expenses, and mandate an inferior rate of return for insurers doing business in California. These proposed regulations are inconsistent with statutory standards for the adoption of regulations under California law and are inconsistent with CIC § 1861.05, because they prohibit insurers from charging rates that are fair and achieving a fair rate of return as required by California law.

Response: The "one-size-fits-all" argument was rejected by the California Supreme Court in *20th Century*. Indeed, both the *Calfarm* and *20th Century* courts made it clear that the Commissioner has the legal authority to take those steps reasonably necessary to make the job of rate regulation manageable. (*20th Century, (*quoting *Calfarm) ,* 8 Cal. 4th 216, 245; 32 Cal. Rptr. 807, 824.) With that said, the regulations contain numerous provisions allowing for the application of company-specific data. And, as is also explained in detail herein, various constitutional safety valves, or variances, have been revised or added to increase flexibility. All told, what detractors have referred to as the "cookie-cutter" characteristic of the regulations has been addressed.

The comments pertaining to rate of return are addressed elsewhere in this rulemaking file.

The Commissioner has determined that regulations are consistent with the law both as to the APA and as to CIC § 1861.05. The ratemaking formula is designed to, and does,

yield a premium that the insurer should receive from its insureds in order to earn a sum amounting to (1) the reasonable cost of providing insurance and (2) the capital used and useful for providing insurance multiplied by a fair rate of return. This is consistent with the general rule that the rate set for a regulated firm is the sum of (1) its cost of service and (2) its capital base multiplied by a rate of return. Indeed, the regulations are designed to and do result in rate indications that are neither excessive nor inadequate *before the* application of variances, which provide a second layer of protection from confiscation. The Commissioner has determined and *the 20th Century Court* agreed that the regulatory scheme is in keeping with the requirement of Proposition 103.

In connection with the comment that the proposed regulations are inconsistent with statutory standards for the adoption of regulations, as the *20th Century* court recognized and as discussed elsewhere in this rulemaking file, these regulations are subject to the ratemaking exception set forth in the California Government Code.

Commentor: Michael A. Walters, Towers Perrin, on behalf of the Association of California Insurance Companies; September 13, 2006; page 1 – 6 and Appendix 1;
Shawna Ackerman, Pinnacle Actuarial Resources, Inc., on behalf of ACIC, PIFC, AIA; September 13, 2006; page 2 – 3 and Exhibit 1 and Transcript page 32;
Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 2 – 3 and Transcript page 19 - 20

Summary: The commentor begins with general and background information summarizing the comments and setting forth the interest and qualifications of the commentor.

Response: Because this portion of the comment is not specifically directed at the Commissioner's proposed revised regulations or to the procedures followed in proposing the revised regulations, no response is necessary. To the extent the comment generally describes the focus of the comments, a detailed response is provided below in connection with the summary of and response to the more detailed comment.

Commentor: Michael A. Walters, Towers Perrin, on behalf of the Association of California Insurance Companies; September 13, 2006; page 9 -12;
Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 7 - 8

Summary: The commentor summarizes the nature of property and casualty insurance, the many types of organizations offering very diverse products, and the variations present in the annual NAIC profitability studies. The efficiency standard impact is mentioned, as is the fact that the formula is too rigid. Economic considerations as to whether a market is competitive and the market share information on the Department's website are referenced. The rationale for the proposed regulation is absent; further technical studies and analysis should be conducted.

Response: To the extent this portion of the comment is not directed at specifically-identified portions of the Commissioner's proposed revised regulations or to the procedures followed in proposing the revised regulations, no response is necessary. To the extent the comment generally describes comments which are discussed in additional detail later, a detailed response is provided below in connection with the summary of and response to the more detailed comment.

Commentor: Michael A. Walters, Towers Perrin, on behalf of the Association of California Insurance Companies; September 13, 2006; page 7 – 8;
Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 3

Summary: The proposed regulations dictate to an insurer what its rates will be (almost to the point of state made rates), contrary to the stated purposed of Proposition 103 and contrary to the practice in other states. Even though ratemaking varies by line and over time, the proposed regulations make actuarial judgment unnecessary.

Response: The proposed regulations do not implement a system of state-made rates, which is a system in which a single rate is specified, to be charged by all carriers. The proposed regulations do not set a single rate for all insurers. Each insurer will have a separate rate, based upon the rate filing it makes and the specific information applicable to its own operations. As discussed elsewhere in this rulemaking file, the proposed regulations set forth numerous areas where company-specific information is used, and the proposed regulations do not make actuarial judgment unnecessary or specify the method by which the insurer determines its own rates. As stated in section 2643.1(a), insurers are free to develop their rates under a methodology of their choosing. As required by Insurance Code section 1861.05 (a), the proposed regulations implement a method for reviewing the result to see if the rate is one that falls within the zone of reasonableness, that is, the range between excessive and inadequate. While the regulations may require specifics as to how data is to be reported, the regulations do not require insurers to employ a specific ratemaking methodology.

Because the regulations do not do not specify the method by which the insurer formulates its own rates, not only do the regulations not hamper actuarial judgment, the regulations do not impact an insurer's exercise of actuarial judgment.

Commentor: Michael A. Walters, Towers Perrin, on behalf of the Association of California Insurance Companies; September 13, 2006; page 8;
Shawna Ackerman, Pinnacle Actuarial Resources, Inc., on behalf of ACIC, PIFC, AIA; September 13, 2006; page 3 and Transcript page 33 - 34;
Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 3, 8 and Transcript page 20 - 21

Summary: A single simple set of rules cannot apply to all lines because ratemaking is complex and requires judgment. A company-specific approach is preferable. Employing an industry average and formulaic approach imposes an incorrect one-size-fits-all

approach and violates the CAS Statement of Principles, which principles are included in the written comments of Mr. Walters and Barger & Wolen. The proposed regulations violate the law because they exclude substantial legitimate costs and expenses.

Response: The argument that these regulations impermissibly impose a "one-size-fits-all" approach was rejected by the California Supreme Court in *20th Century*. Indeed, both the *Calfarm* and *20th Century* courts made it clear that the Commissioner has the legal authority to take those steps reasonably necessary to make the job of rate regulation manageable. (*20th Century, (*quoting *Calfarm) ,* 8 Cal. 4th 216, 245; 32 Cal. Rptr. 807, 824.) With that said, the regulations contain numerous provisions allowing for the use of company-specific data. And, as is also explained in detail herein, various constitutional safety-valves, or variances, have been revised or added to the regulation to enhance flexibility.

The ratemaking formula is designed to, and does, yield a premium that the insurer should receive from its insureds in order to earn a sum amounting to (1) the reasonable cost of providing insurance and (2) the capital used and useful for providing insurance multiplied by a fair rate of return. This is consistent with the general rule that the rate set for a regulated firm is the sum of (1) its cost of service and (2) its capital base multiplied by a rate of return. Indeed, the regulations are designed to and do result in rates that are neither excessive nor inadequate *before the* application of variances, which provide a second layer of protection from confiscation. The Commissioner has determined and the *20th Century* court agreed that there is nothing in these regulations offensive to or violative of the Casualty Actuarial Society "Statement of Principles Regarding Property and Casualty Insurance Ratemaking"

Commentor: Michael A. Walters, Towers Perrin, on behalf of the Association of California Insurance Companies; September 13, 2006; page 11 - 12

Summary: Comparison is made to utility rate setting.

Response: Because this portion of the comment is not specifically directed at the Commissioner's proposed revised regulations or to the procedures followed in proposing the revised regulations, no response is necessary. To the extent the comment generally describes comments which are discussed in additional detail later, a detailed response is provided below in connection with the summary of and response to the more detailed comment.

Commentor: Michael A. Walters, Towers Perrin, on behalf of the Association of California Insurance Companies; September 13, 2006; page 13 -14;
Shawna Ackerman, Pinnacle Actuarial Resources, Inc., on behalf of ACIC, PIFC, AIA; September 13, 2006; page 4

Summary: Alternatives should have been considered, including rating examinations on site at an insurer, and comparisons to the rates of other insurers. There are sufficient other ways to identify controversial filings. There is serious potential for negative,

unintended consequences. There must be full consideration of alternative, company-specific approaches. CDI should test the proposed regulatory structure against a sample of rate filings.

Response: In the years leading up to the promulgation of these regulations, three workshops were held and a rulemaking hearing was also conducted. Prior to commencement of this rulemaking proceeding (as noted in the comments), dozens of alternative approaches were discussed, debated and considered over a period of several years. Implying the Commissioner did not allow for input from interested person is simply incorrect, and does not reflect the unusual effort the Commissioner made to solicit, receive and consider alternatives. And it should be noted that as a result of input from interested persons in the years since the current regulations were adopted, in case-by-case reviews, in the several workshops and in the rulemaking hearing, numerous alternatives have been suggested and considered and a significant number of revisions have been made to the proposed regulation as a result of these comments.

The regulations proposed for adoption in this rulemaking proceeding, in general, simply "codify" the system that has been utilized for many years, having evolved since the early 1990's in case-by-case determinations. The Commissioner has determined that it is prudent and necessary to codify the methodology to ensure consistent treatment of insurers and enhance accuracy and transparency, among other things.

While rating examinations are conducted by the Department and serve many useful and important purposes, they do not, by themselves, satisfy the rate approval provisions of Proposition 103. Likewise, comparisons of the rate of other insurers do not necessarily ensure that an insurer's rates are neither excessive nor inadequate.

To the extent the comment can be read to stand for the premise that these regulations should be abandoned in favor of simply a case-by-case determination approach, the comment is rejected. By law the Commissioner is authorized to do what it takes to keep the job of rate regulation manageable.

Commentor Michael A. Walters, Towers Perrin, on behalf of the Association of California Insurance Companies; September 13, 2006; page 19

Summary: The assumption of industry ratios may only mean a 1 – 2% difference for each component, but could add up to a material difference overall.

Response: Although certain portions of the regulations use industry averages, other portions of the regulations rely on company-specific data. The regulations are designed to ensure that, overall, an insurer's rates are not excessive or inadequate. As previously indicated, the variances authorized by the regulations provide additional assurances that the rates are not inadequate.

Commentor Michael A. Walters, Towers Perrin, on behalf of the Association of California Insurance Companies; September 13, 2006; page 19

Summary: A company should be able to calculate its actual factors for the line being filed for, with supporting calculations. A cumulative difference of ten points in rate level can have a material effect on an insurer that is leveraged at 2:1 in that line. And operating profits are well under ten percent for many lines, so that can mean the difference between a pre-tax profit and loss.

Response: As set forth in existing section 2643.1 of the Department's regulations, "while companies remain free to formulate their rates under any methodology, the Commissioner's review of those rates must use a single, consistent methodology. As set forth elsewhere in this rulemaking file, the regulations (including the variances) are designed to, and do, ensure that an insurer's rates are not inadequate.

Commentor: Richard J. Roth, Jr., Bickerstaff, Whatley, Ryan & Burkhalter, Inc.; September 11, 2006; page 7

Summary: The goal of a regulation should be to identify the problem and devise the minimum amount of regulation to address the problem. This draft is overkill, and does not improve the credibility or reputation of the Department, since many features are simply not correct. This is not the first draft, and successive drafts are not getting better. It appears the drafters of the regulation are not working closely with FAD and the actuarial staff within the Department.

Response: The Commissioner has determined that these regulations provide an appropriate framework to allow all interested persons to know how the Department will review rate change applications. The ratemaking formula set forth in the regulations complies with the law, is a fairly standard ratemaking formula, and was approved by the Supreme Court in the *20th Century* case. The Commissioner rejects the comment that this regulation is "overkill," because the public is entitled to know on what basis the Department can be expected to approve (or not approve) a rate application.

The speculation that the drafters of the regulation are not coordinating with FAD and the actuarial staff is merely that.

While some people may believe that the goal of a regulation should be to identify the problem and devise the minimum amount of regulation to address the problem. Others perceive the goal differently. The Commissioner has determined that the regulations do not impose unnecessary regulatory requirements. They strike an equitable balance between manageability and flexibility such that the job of rate regulation is manageable, consistent treatment is ensured, and the regulations provide ample protections for both insurers and insureds. "Less" regulation would not achieve these goals.

Commentor: Richard J. Roth, Jr., Bickerstaff, Whatley, Ryan & Burkhalter, Inc.; September 11, 2006; page 1

Summary: A 1991 speech by George K. Bernstein is attached as purportedly relevant to the draft regulation. The article provides an overview of total rate of return methodologies so that actuaries will be better able to understand how those methodologies relate to pricing, and discusses the politics of state insurance regulation that created and drive that methodology. It is reportedly an example of why increasing federal regulation of insurance is being contemplated. It refers to a 1979 speech and a 1976 article on the same subject. The article alleges that often, in response to a rate application, the response is not, is the filing accurate, but how will a premium increase be received. The article discusses a 1969 attempt to end prior approval in New York and the possibility that insolvency funds may be a reason rates are artificially suppressed. Regulators have lost sight of the fact that their primary function should be solvency regulation. The article discusses five insurer insolvencies and the fact that commissioners should rate insurers for relative solidity. The article references use of non-authorized offshore insurers.

Response: To the extent these are general comments and do not directly relate to the regulations at issue in this rulemaking proceeding, a detailed response is not required. To the extent the comments indicate that rate applications are not evaluated based upon the content of the application, the Department notes that the purpose of these regulations is to clearly set forth the basis on which the Department will review rate applications submitted to the Department. If the proposed rate change complies with all applicable legal requirements and falls with the range between excessive and inadequate, as described in the regulations, a rate application will be approved. The Department also notes that many of the theories set forth in the article do not reflect or recognize the current state of California law and, to that extent, cannot be adopted in California regulations. For example, the article refers to 1962 and 1966 and subsequent activities related to open competition. However, in 1988, California voters replaced California's open competition system with one requiring prior approval. Open competition does not reflect the state of the law in California. As to the five insurer insolvencies referenced, no specifics are provided, so the Department is unable to respond in detail. While solvency regulation is a significant focus of the Department's activities, the focus of these regulations is rate review, not solvency *per se*. To the extent the article references use of non-authorized offshore insurers, it is irrelevant to the regulations which are the subject of this rulemaking proceeding, since these regulations apply to insurers admitted to do business in California.

Commentor: Shawna Ackerman, Pinnacle Actuarial Resources, Inc., on behalf of ACIC, PIFC, AIA; September 13, 2006; page 4 – 7

Steven Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; Transcript page 20 - 21

Summary: CDI should reconsider the work performed in 1997 and determine which alternatives, if any, are appropriate for further review and discussion and hold a further workshop and testing. The commentor summarizes work earlier conducted and indicates that a similar comment was made in connection with the June 25, 2005, workshop. Administrative convenience does not outweigh the need for a fair ratemaking

methodology. The regulations are not necessary because the Department has been able to review rate applications without the benefit of these regulations.

Response: CDI is well aware of the work performed over the years on possible revisions to the existing rate review regulations. Many of the staff members working on this regulatory proposal have been involved in the various earlier projects to update the existing regulations. In addition to the long-standing work on revisions to the existing regulations, the CDI held three workshops in connection with this proceeding. One of the Commissioner's responsibilities is to set the regulatory parameters in this area, subject to existing legal standards. The Commissioner has determined that the various alternatives have been sufficiently studied and has updated the regulations to account for the passage of time. To the extent the commentor merely summarizes work conducted ten years ago, those are not comments on the existing regulations, and a specific response is therefore not required. The Commissioner has determined that regulations governing the review of rate applications are unnecessary. Interested members of the public are entitled to a transparent process and to know how the Department will review and approve or disapprove rate applications. To the extent a company presents unique and specific circumstances which are not accounted for in the rate review process, variances are available.

Commentor: Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 3 – 4

Summary: The Office of Administrative Law must review all regulations and determine that they pass six specified standards. These regulations do not.

Response: In the *20th Century* case the Supreme Court held these regulations meet the requirements of the ratemaking or rate-setting exception set forth in Government Code Section 11340.9(g). *20th Century*, 8 Cal. 4th 216, 271; 32 Cal. Rptr. 807, 841.
Even though these regulation are subject to the rate-making exception, the Commissioner rejects the contention that the proposed regulations fails to meet the six specified standards, noting that the existing regulation were upheld by the Supreme Court in *20th Century*. As set forth elsewhere in this rulemaking file, the Commissioner rejects the comment that these regulations impose state mandated uniform rates, arbitrary cost reductions, and a one-size fits all approach.

Commentor: Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 4 – 7 and Transcript page 22 - 24

Summary: The regulations are beyond the Commissioner's authority. The Commissioner may review rates but he may not dictate the rates insurers must charge or impose state made rates. The Commissioner has authority to review rates, not to dictate the rates insurers must charge or impose state made rates. The Commissioner lacks authority to adopt these regulations. *20th Century* involved rollbacks and confiscation and did not recommend a general formula for prospective ratemaking or authorize the Commissioner to cap an insurer's rate of return. The comment provides a summary of the

history of Proposition 103. Under Proposition 103 and *20th Century*, insurers must be permitted to charge rates that allow them to recover costs and have an opportunity to earn a fair rate of return. Contrary to the rollback system, *20th Century* provides that under the prior approval system, the insurer is effectively free to set for itself whatever rate it chooses provided that its rate is neither excessive nor inadequate.

Response: As set forth above, the Commissioner does not set rates though application of these regulations. Insurers are free to set rates in any manner they choose but review of those rates must use a single, consistent methodology. The regulations represent that methodology. As such the regulations do not impose state-made rates, which is a system in which a single rate is specified, to be charged by all carriers. The proposed regulations do not set a single rate for all insurers. Each insurer will have a separate rate, based on the specifics of its own operations. The Commissioner incorporates herein by reference his responses made to similar comments elsewhere in this rulemaking file.

The legal argument reflected in this comment is premised on the incorrect argument that in the *20th Century* case the Supreme Court only upheld and approved application of the ratemaking formula and the regulations in general as to rollbacks, which were retrospective. In other words, the Supreme Court did not authorize the use of the prospective aspect of the ratemaking formula as to prior approval. This assertion is incorrect.

As to "retrospective" nature of the rollbacks the *20th Century* court held the application of the regulations as to rollback were prospective:

The rate regulations as to rollbacks may properly be considered prospective. The "fixing of a rate and the reducing of that rate are prospective in application ...." (*Consumers Lobby Against Monopolies v. Public Utilities Com., 25 Cal.3d at p. 909* (lead opn. by Mosk, J.); accord, *id. at p. 916* (conc. & dis. opn. of Richardson, J.).) The ordering of a refund of rates is "akin to a reduction in rates," when, as here, the rates in question were charged "pending a determination of [their] legality ...." (*Id. at p. 910* (lead opn. by Mosk, J.); accord, *id. at p. 916* (conc. & dis. opn. of Richardson, J.).) It follows that the ordering of a refund of rates is itself prospective. Since the regulations in question serve such a refund, they may soundly be viewed to share its character, *20th Century*, 8 Cal. 4th 216, 281; 32 Cal. Rptr. 807, 848.

Aside from the characterization of the rollbacks as being prospective in nature, throughout the *20th Century* case the Court approved application of the ratemaking formula and the regulations both generally, as in the prior approval context and specifically as to rollbacks. Nowhere in *20th Century* does the court indicate that its holding is limited to the portion of the regulations pertinent to rollbacks. *20th Century* is replete with discussions relating to the ratemaking formula including detailed analysis of the factors which make up that formula. On every occasion, and in general as to the entirety of the rulemaking scheme, the Supreme Court approved the regulations.

Under Proposition 103, as modified by *Calfarm Insurance Company v. Deukmejian* (1989) 48 Cal.3d 805, insurers are entitled to the opportunity to earn a fair and reasonable rate of return. Court decisions interpreting the "fair rate of return" standard make it clear that the opportunity to achieve a fair return must be provided only to those who conduct their operations in a reasonably efficient manner. *Greenleaf Finance Company v. Small Loans Reg. Bd.* (1979) 385 N.E. 2d 1364. Thus, insurers may only pass on reasonable expenses to insurance consumers. The efficiency standard complies with these legal standards.

The regulations require the Commissioner to adopt a maximum and minimum permitted premium, corresponding to the range of fair and reasonable profits. (§ 2644.15.) As long as the insurer's premium rate, less its reasonable expenses, leaves it a profit (i.e., rate of return) lying within this range, the premium rate is neither excessive nor inadequate. Thus, the range of reasonable *rates of return* yields the range of reasonable *rates*, making specific the statutory "excessive, inadequate" language defining the bounds of the insurer's pricing discretion.

However, it must be noted that the regulations do not cap an insurer's rate of return and neither do they cap profit. The regulations are used to review an insurer's proposed rate and the regulations do this though application of a ratemaking formula. The maximum and minimum rates of return adopted by the Commissioner are but one of many factors used in that formula. While the regulations do test for the reasonableness of expense and do apply a rate of return methodology, the insurer is free to improve efficiencies and use other cost reduction measures to earn a higher rate of return than that adopted in the proposed regulations.

The comment indicates that under Proposition 103 and *20th Century*, insurers must be permitted to charge rates that allow them to recover costs and have an opportunity to earn a fair rate of return. Contrary to the rollback system, *20th Century* provides that under the prior approval system, the insurer is effectively free to set for itself whatever rate it chooses provided that its rate is neither excessive nor inadequate. The Commissioner agrees with this statement and the regulations are designed to and do meet these legal requirements.

Commentor: Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 8 – 9
Shawna Ackerman, Pinnacle Actuarial Resources, Inc., on behalf of ACIC, PIFC, AIA; Transcript page 34

Summary: The proposed use of averages, caps, and elimination of expected future costs will prevent the Department from determining if a proposed rate is excessive or inadequate. Company specific data is a better measure of future costs. The expected value of all future costs associated with an individual risk transfer are being changed and company-specific information is removed from the review process, contrary to the actuarial principles and section 1861.05. Even appreciating the desire to allow only reasonable expenses in the rate, an average value is no guarantee of a reasonable expense

level and no guarantee of efficiency. Higher than average claims handling expenses may lead to lower rates. Expense caps may act as a disincentive to insurers to maintain adequate claims staff and 24-hour claims centers.

Response: Please see response to similar, more specific, comments elsewhere in this rulemaking file.

Commentor: Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 9;
Shawna Ackerman, Pinnacle Actuarial Resources, Inc., on behalf of ACIC, PIFC, AIA; Transcript page 32 - 33

Summary: CDI should hold further workshops. There is no basis to believe that the problem areas have been adequately identified or addressed and the variances are too narrow.

Response: In the years leading up to the promulgation of this regulation, three workshops were held and a rulemaking hearing conducted. As has already been stated in response to other, similar comments elsewhere in this rulemaking file, numerous alternative approaches were discussed, debated and considered. As a result of input from interested persons in the many years since the current regulations were promulgated, many alternatives have been suggested and considered and numerous revisions have been made to the proposed regulation as a result of these comments. For these reasons the Commissioner has determined that additional workshops are not necessary.

Commentor: Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 1 - 3

Summary: The proposed regulations retain certain characteristics of the rollback regulation ill-suited to prior approval rate making.

Response: To the extent these comments are general in nature, they are responded to accordingly. Where the comments are made specific they are responded to specifically.

The ratemaking formula both as to prior approval and rollbacks was upheld by the Supreme Court in *20th Century*. Many modifications and revisions have been made over the years and procedures and methodologies have developed as the result of thousands of case-by-case reviews. The proposed regulations are the result of these many years of experience and reflect, generally and specifically, the methodologies that have been in use for quite some time.

Commentor: Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; pages 1 – 3.

Summary: In many instances the regulations set forth the methodology for updating mandated input values, making updating more mechanical. How input values are to be

computed are incomplete or ambiguous in several instances. (Attachments 1 – 2 of comments are examples provided at the workshop.) Clearer descriptions of how the input values are to be computed are necessary. There needs to be a procedure by which insurers can confirm that the Department's computations are accurate. The underlying data should be posted on the Department's website within 30 days of receipt of the data by the Department. This will prevent surprises, permit insurers to compute their own input values and allow confirmation of the accuracy of the Department's computations.

The former "generic factors" have been replaced in some instances with company-specific data and in other instances with mandated values and/or procedures that function in a similar fashion to the generic factors, but without evidentiary input. Although this allows the values to be known with relative certainty, it can introduce stale or inappropriate values, seemingly without recourse. There is generally no basis for an insurer to assert that a promulgated value is inappropriate in the circumstances and produces an absurd result. Not including sample calculations does not permit a fair evaluation of the regulation.

Response: In response to this and similar comments the Commissioner issued a 15-day notice setting forth how the various factors were calculated and including background data and other pertinent information. That notice and the accompanying documents are included in this rulemaking file. The updated data will be made readily available so insurers and other interested members of the public will be able to confirm and test all future calculations.

Commentor: Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 3

Summary: Use of a calendar year method may tend to produce distorted results depending on specific factors adopted. Unless the regulations address this through variances for good cause, the maximum permitted earned premiums for short and longer tailed lines may be biased relative to more accurate cash flow models.

Response: This is a general comment and is relevant to several different factors in the ratemaking formula. Specific responses are provided elsewhere in this rulemaking file. The Commissioner has determined that the methodology does not produce distorted results. However, as the comment indicates, several variances are included in the regulations to ensure that the rates are appropriate.

Commentor: Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 3 - 4

Summary: In several cases, a maximum permissible value is set at or near the average value over a range of typical insurers. Setting the maximum at the average introduces a downward bias unless a variance applies. Examples are provided, particularly regarding rate of return. This can be addressed by a default value that can be used by all companies

and allowing the filing of higher values if justified by an actuarially accepted method or by setting the maximum higher than the 50th percentile.

Response: This is a general comment relevant to several different factors in the ratemaking formula. Specific responses are provided, in connection with the specific section, elsewhere in this rulemaking file.

Commentor: Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 3 - 4

Summary: The regulations are systematically biased against smaller insurers in three key specified areas. Smaller insurers tend to have higher expenses. Large insurers with small California market shares also tend to have higher than average costs. Smaller insurers must purchase more reinsurance and have higher reinsurance costs. The regulations favor large insurers with large California market shares and will produce a market dominated by a small number of large insurers with large market shares.

Response: The comment is general in nature and relevant to several different aspects of the ratemaking formula. However, the Commissioner responds that he has determined that the regulations do not favor large California insurers with large California market shares. The regulations recognize both the premium volume and the unique aspects of different insurers. Additionally, the Commissioner incorporates by this reference his responses to the specifically-referenced regulation sections set forth elsewhere in this rulemaking file.

Commentor: Timothy J. Shannon, Jr.; California Association of Professional Liability Insurers (CAPLI), dated September 12, 2006; page 1 – 2

Summary: A cover letter was attached to the comments submitted on behalf of CAPLI by James Hurley.

Response: A specific response is not required.

Commentor: Timothy J. Shannon, Jr.; California Association of Professional Liability Insurers (CAPLI), dated September 12, 2006; page 1 – 2

Summary: CAPLI objects to medical malpractice not being treated as a specialty line. CAPLI would like to know the rationale behind the decision to not allow medical malpractice insurance to be designated specialty.

Response: The treatment of medical malpractice insurance was revised in the October 5, 2006, version of these regulations. Although medical malpractice is not a specialty line in that version, the result is comparable. Please see further discussion elsewhere in this rulemaking file.

Commentor: Jeff Donaldson, Devin O'Brien, Hillary Rowen; Supplemental Comments by The Doctors Company, dated September 13, 2006; page 1

Summary: The proposed regulation does not treat medical malpractice as a specialty line. The rationale given by CDI provides that treatment of medical malpractice as a specialty line is not needed because "unique issues related to medical malpractice are separately addressed." This statement appears to refer to the new language in section 2644.4(d), which states: "For policies providing death, disability and retirement coverage, the projected losses for this coverage shall be calculated using a sound actuarial method."

Response: The Commissioner incorporates herein his response to a similar comment made immediately above.

Commentor: Jeff Donaldson, Devin O'Brien, Hillary Rowen; Supplemental Comments by The Doctors Company, dated September 13, 2006; page 1

Summary: Specialty lines are subject to alternative calculations. Section 2644.4(e) provides that specialty lines losses need not be trended and adjusted pursuant to 2644.5 through 2644.7, but may be subject to an alternative computation. Section 2644.8 allows an alternative calculation of defense and cost containment expenses for specialty line. Both alternative computations must be actuarially sound.

Response: This comment sets forth the applicable regulatory provision as of the September version of these regulations. However, the regulations have subsequently been amended, and, pursuant to section 2642.7(c), rates for specialty lines shall generally be approved or disapproved using the most sound actuarial method. To the extent the comment refers to medical malpractice rates, section 2644.4(d) applies. The Commissioner incorporates by this reference his further responses to other comments regarding professional liability rates elsewhere in this rulemaking file. To the extent the commentor is merely providing general background comments, a further response is not required.

Commentor: Russina Sgoureva; Progressive West Insurance Company, dated September 13, 2006; page 9

Summary: The regulations require ancillary income be accounted for. While this is appropriate the regulations fail to recognize "offsets" to ancillary income that should also be considered. Premium earned and not collected detracts from ancillary income. Premium financing may or may not result in ancillary income which impacts the amount of premium reserves available for investing. The better approach would be to use the company specific ancillary income numbers reported on the IEE in the annual statement.

Response: Because this is not a comment on a regulation section proposed to be changed, a response is not required.

Section 2642.4 Pure Premium

Commentor: American International Group (AIG) by Mary B. Gaillard, September 12, 2006, Page 2, oral statement of Mary Gaillard (AIG), transcript pages 39-40.

Summary: The proposed revision of the definition of pure premium does not allow for the inclusion of company-specific adjuster expenses in the development of a rate. This directly contradicts the ratemaking principles which define a rate as "an estimate of the expected value of future costs," which include all allocable loss adjustment expenses (ALAE). If a company directly assigns adjuster expenses to specific claims, then they should be incorporated into the ratemaking formula using company specific experience. The definition of pure premium should be left as it currently exists.

Response: In response to other comments which noted that "pure premium" was defined in this section but never used elsewhere in the regulations, this section was proposed for deletion in the October 5, 2006, version of these regulations.

Company-specific "adjusting and other expenses" (AOE) are now calculated on an industry-wide basis. "AOE is a factor in the calculation of the efficiency standard. This is discussed in great detail in the responses to comments relating to the efficiency standard.

Commentor: Shawna Ackerman, Pinnacle Actuarial Resources, Inc., on behalf of ACIC, PIFC, AIA; September 13, 2006; page 8 and Transcript page 35 - 36;
Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 9

Summary: Pure premium is defined, but never again referred to. It is unclear what purpose this section serves. It lacks clarity. The original regulations contemplated a pure premium ratemaking methodology, as evidenced by the definition of pure premium and other provisions of the regulations. It appears the Department is now using a loss ratio method and calculating rate indications rather than rates per exposure.

Response: In response to this comment, the section has been proposed for deletion from the proposed regulations. The basis for the statement that the regulations create a mishmash between the loss ratio method and a pure premium method is not set forth in the oral comments. Therefore, the Department is unable to provide a specific response to that portion of the comment, as set forth at page 36 of the transcript.

Commentor: Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 5

Summary: The revision replaces allocated loss adjustment with defense and cost containment.

Response: Because the comment simply describes the change, a specific response is not required. However, the Commissioner notes that in 1998 the National Association of Insurance Commissioners revised the definitions of Allocated Loss Adjustment Expense (ALAE) and Unallocated Loss Adjustment Expense (ULAE) in order to improve the consistency of reporting among all insurers. The term now used by the NAIC and in the revisions is "Defense and Cost Containment Expenses" otherwise known as DCCE. The Commissioner has adopted this change to be consistent with the other states, and has therefore altered the terminology in the proposed revisions pursuant to the NAIC model.

Section 2642.5 Rating Period

Ratemaking is the process whereby historical experience data is used to predict, as accurately as possible, future costs associated with the transfer of risk. The rating period is the period of time to which the proposed rate would apply, in other words, the period of time in which the rates will be in effect.

Commentor: Mary B. Gaillard, on behalf of AIG, September 12, 2006, Page 2.

Summary: The projected rating period should not be restricted to one year commencing on the effective date of the rates. This does not consider six-month policy periods, which are the norm in personal automobile, or multi-year policy periods, which exist in some commercial lines.

Response: The existing regulation provides that, unless otherwise determined, the rating period shall be one year. The proposed change deletes "unless otherwise determined." This proposed revision thus defines the rating period as one year. A one-year rating period in prospective ratemaking is an historically accepted actuarial standard. The section explicitly places no limits on the number of rate filings that may be made but merely uses a one year period as the period of time which must be accounted for in a rate application.

Specifying a rating period does not put any restrictions on policy terms. The rating period is used only for trend calculation.

Using one year as a rating period is a standard and accepted practice. Basing the rating period on policy periods is not a standard and accepted practice and would add instability and confusion to the process. The Commissioner notes that many auto policies in California are sold as one-month policies. Certainly application of a one-month rating period would be ludicrous. Even in personal auto, where six-month policies are common, companies typically submit rate applications annually, not every six months.

The Commissioner has determined that to ensure consistency in the process and to keep rate regulation manageable, a rating period of one year is reasonable and prudent. Any insurer which believes this standard puts it at a disadvantage may make rate filings more frequently. Doing so would effectively result in a different rating period.

The rating period for commercial lines may be properly limited to one year even where the policies are multi-year policies because commercial policies often apply experience rating. As such, the policies are reviewed for claims and re-rated on an annual basis. It is not standard actuarial practice to base the rating period on the policy period. The Commissioner has determined that to ensure consistency in the process and to keep the job of rate regulation manageable, a rating period of one year, which is the period set forth in the existing regulations, is reasonable and prudent.

Commentor: Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 5

Summary: The revisions to 2642.5 are consistent with prospective rate making.

Response: As the comment is in accord, a specific response is not required.

Section 2642.6 Recorded Period

The "recorded period" is the time period from which historical data are taken to provide the basis for the proposed rate.

Commentor: Pamela Pressley, on behalf of the Foundation for Taxpayer and Consumer Rights (FTCR); September 13, 2006, page 1.

Summary: In circumstances where the experience from the most recent three years is sparse and/or limited, it would be useful to allow more years of experience, up to some maximum number of years, to increase the credibility of the experience.

Response: In response to this and other similar comments the regulations were revised.

The proposed revision allows the insurer to deviate from the three year recorded period where company-specific data, for any given line, does not meet credibility standards. It also allows the insurer to use company-specific data to meet the credibility standard. Proposed section 2642.6 allows for contingencies where there is not enough credible, company-specific data available.

The Commissioner has determined that this revision to the current regulation is reasonable and prudent due to the experience gained in years of case-by-case determinations and in response to comments and suggestion made over time, during this rulemaking and /or in the previous workshops. The Commissioner considered these comments and determined that in the interest of enhancing flexibility and in the interest of garnering the most accurate results possible contingencies must be made to address credibility concerns.

Commentor: Randall Farwell, on behalf of the Interinsurance Exchange of the Automobile Club; September 13, 2006; page 3.

Summary: The proposed requirement for the recorded period eliminates flexibility in that it does not allow the insurer to consider the line of business, the credibility of data, changing conditions and company size. The regulation should allow for more flexibility to address these concerns.

Response: In response to this and similar comments, as discussed above and incorporated herein by this reference, the regulations were amended.

Commentor: Shawna Ackerman, Pinnacle Actuarial Resources, Inc., on behalf of ACIC, PIFC, AIA; September 13, 2006; page 8;
Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 9

Summary: This section limits the experience period, but it is commonplace to use longer experience periods. Allowing more years of experience will decrease the need to rely on a formulaic approach to credibility. Additionally, for some lines and larger companies, less experience will lead to a credible rate indication. This section is overly restrictive and unnecessary.

Response: As discussed above, in response to this and similar comments this section has been amended and now provides that the recorded period shall be the most recent three years for which reliable data are available, unless (1) the credibility of that experience is less than the value contained in section 2644.23(g), in which case additional years shall be added to the recorded period until sufficient years are used to reach the credibility standard or (2) the data are fully credible with fewer than three years experience, in which case only as many years as needed to be fully credible shall be used.

Section 2642.7 Lines of Insurance

Commentor: Mary B. Gaillard, on behalf of AIG, September 12, 2006, Page 2; oral statement of Mary Gaillard (AIG), September 13, 2006, transcript page 39.

Summary: The proposed definition of specialty lines should be expanded to define professional liability – including medical malpractice -- as it appears in the current regulations.

Response: The October 5, 2006, version of these regulations revises the manner in which professional liability rates are reviewed. This and similar comments are discussed in connection with the comments received on the October 5 version, and incorporated herein by this reference.

Commentor: Mary B. Gaillard, on behalf of AIG, September 12, 2006, Page 2.

Summary: Other products should be considered "specialty lines," including warranty/mechanical breakdown insurance, aircraft, and high value homeowners.

Response: In response to a decision issued following a medical malpractice rate hearing, the Commissioner determined that changes involving medical malpractice were appropriate. Changes to the listing of other specialty lines are beyond the scope of this rulemaking proceeding. At the present time, the Commissioner has determined it would not be prudent to increase the number of lines designated specialty.

With that said, §2644.4(c) provides that for policies providing multi-year coverage, such as mechanical breakdown, projected losses may be calculated on a policy-year basis. This change was made, at least in part, in response to comments received regarding mechanical breakdown and other multi-year coverages.

Commentor: Pamela Pressley, on behalf of the Foundation for Taxpayer and Consumer Rights (FTCR); September 13, 2006, pages 1-2.

Summary: We support the position of the CDI to exclude medical malpractice insurance from being a specialty line of insurance. Medical malpractice insurance is amenable to standard ratemaking procedures and does not need to be, and should not be, treated as a specialty line of insurance for which alternative methodologies for calculating projected losses may be allowed.

Response: As the comment is in accord with the proposed methodology no response is required. However, subsequent changes were made regarding the treatment of medical malpractice, and the Commissioner incorporates herein by this reference the responses made to those comments.

Commentor: Pamela Pressley, on behalf of the Foundation for Taxpayer and Consumer Rights (FTCR); September 13, 2006, pages 1-2.

Summary: As insurers are allowed to use methodologies for adjusting losses other than that set forth in sections 2644.5 through 2644.7 in setting rates for medical malpractice insurance, there is no need for the same exception to apply to death, disability, and retirement coverage. Death, disability, and retirement coverage is sold in conjunction with medical malpractice insurance, so death, disability, and retirement coverage is subject to the same exception. The CDI has proposed a change to the regulations to deal with this specific issue (see proposed regulation text Section 2644.4(d)).

Response: Please see response to comment above, which is incorporated herein by this reference.

Commentor: Shawna Ackerman, Pinnacle Actuarial Resources, Inc., on behalf of ACIC, PIFC, AIA; September 13, 2006; page 8 – 9

Summary: Medical malpractice has been deleted as a specialty line. The key benefit of specialty line status is the ability to tender an alternative computation of projected

losses and projected allocated loss adjustment expenses. The current definitions should be reviewed. Specialty lines should be expanded to include programs which have an average annual policy premium of a certain size.

Response: The regulations have been revised in response to this and other comments.

For professional liability and errors and omissions coverage, section 2644.4(d) recognizes that the insurer may use alternative computations for projected losses.

As to expanding section 2642.7(d)(1), the Commissioner is not persuaded. The Commissioner has determined that the lines currently designated as specialty are all of a type that are sold to sophisticated consumers by sophisticated specialty lines brokers. Under these circumstances consumer protection concerns associated with sales of commodity lines to less sophisticated consumers are significantly diminished. In drafting these regulations the Commissioner carefully weighted the risks to consumers in allowing more "specialty" lines against insurers' interests in regulatory exemptions. Where the key rationale for allowing specialty lines treatment is not present, the increased threat to consumers is a pressing concern. Along with these considerations is the fact that the Commissioner must keep the job of rate regulation to a manageable size in order to carry out the requirements set forth in Proposition 103. A larger annual premium threshold is not persuasive. Therefore, at the present time, the Commissioner has determined it would not be prudent to expand the designating of specialty line as suggested. As indicated above, changes such as these are beyond the scope of this rulemaking proceeding. To the extent the comments relate to an unchanged portion of the regulation text, a detailed response is not required.

Commentor: Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 9

Summary: Medical malpractice is excluded as a specialty line. The key benefit of specialty line status is the ability to tender alternative computations of projected losses and ALAE.

Response: In response to this and other comments, and as discussed above, the regulations have been revised to address the commentor's concern.

Commentor: Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 10

Summary: The commentor objects to the current specialty insurance subcategories. The current definitions of specialty line should be reviewed. Specialty lines should be expanded to include programs which have an average annual policy premium of a certain size.

Response: The Commissioner incorporates by this reference his responses to the comments above. Additionally, because this is not a comment specifically directed a t

the Commissioner's proposed revised regulations or to the procedures followed in proposing the revised regulations, no response is necessary.

Commentor: James Hurley; on behalf of California Association of Professional Liability Insurers (CAPLI), September 12, 2006; page 1

Summary: Medical malpractice should be designated a specialty line of insurance because it is inherently more volatile than most other commodity coverages.

Response: The regulations have been revised in response to this and other similar comments. Although professional liability and errors and omissions coverage remains a commodity line, section §2644.4(d) allows an alternative computation (other than those specified in sections 2644.5 through 2644.7) for projected losses. The Commissioner has determined this to be a reasonable approach to recognize the unique nature of medical malpractice coverage. This is similar to the treatment currently allowed for medical malpractice in the existing regulations.

Commentor: James Hurley; on behalf of California Association of Professional Liability Insurers (CAPLI), September 12, 2006; page 1

Summary: Medical malpractice should be designated a specialty line of insurance because it is written, primarily, by specialty insurers with a high concentration of California medical malpractice exposure and a more limited financial base relative to most other insurers writing commodity coverages.

Response: The regulations have been revised in response to this and other similar comments. Please see response above, which is incorporated herein by this reference. The Commissioner also notes that a 2644.27(f)(5) variance is available where an insurer writes at least 90% of its direct premium in one line or in California and its mix of business presents investment risks different from the risks that are typical of the line as a whole.

Commentor: James Hurley; on behalf of California Association of Professional Liability Insurers (CAPLI), September 12, 2006; page 2.

Summary: Medical malpractice should be designated a specialty line of insurance because the coverage produces volatile, inappropriate and actuarially unsound results over time when subject to the mechanized procedures of section 2644.6 (loss development) and 2644.7 (trend.) These problems are exacerbated by section 2642.6 (recorded period) which requires use of the latest three year experience. That period of time is too short for medical malpractice line.

Response: The regulations have been revised in response to this and other similar comments. Under proposed §2644.4(d), for professional liability and errors and omissions coverage, the insurer may use alternative computations for adjusting projected losses other than those specified in sections 2644.5 through 2644.7. Therefore, medical

malpractice is not subject to the procedures of section 2644.6 (loss development) and 2644.7 (trend).

In response to this and other comments, section 2642.6 has also been amended to allow additional years to be added to the recorded period until sufficient years are used to reach the credibility standard.
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Commentor: James Hurley; on behalf of California Association of Professional Liability Insurers (CAPLI), September 12, 2006; page 2.

Summary: The medical malpractice market does not have the financial base or diversification that exists for most writers of commodity lines. Medical malpractice insurers do not have the diversification protections of other companies and as such are more susceptible to solvency issues.

Response: As stated above several amendments to the regulation have been made to address medical malpractice insurance.

No compelling evidence leads the Commissioner to believe medical malpractice insurers have such a limited financial base as to put them in a constant state of financial peril. California has strict, specific and ample laws relating to the financial integrity of insurance companies, and the Department constantly monitors insurers' financial condition.

For these reasons and because a number of variance request would seem applicable in the circumstances as described in the comment, the Commissioner declines to make further amendments to the regulations as they apply to medical malpractice insurers.

Commentor: James Hurley; on behalf of California Association of Professional Liability Insurers (CAPLI), September 12, 2006; page 2.

Summary: Medical malpractice should be treated as a specialty line because is a high severity low frequency type of insurance

Response: The regulations have been amended to address the concerns set forth in this comment as described in detail above. Applicable variances are available.

Commentor: James Hurley; on behalf of California Association of Professional Liability Insurers (CAPLI), September 12, 2006; page 2.

Summary: In medical malpractice insurance there are significant time-lags between the occurrence and resolution of a claim. This impacts fiscal viability and argues in favor of medical malpractice being treated as a specialty line.

Response: The regulations have been amended to address the problems addressed in this comment. Specifically the regulations have been revised in response to this and

other similar comments. Pursuant to proposed §2644.4(d) for professional liability and errors and omissions coverage, the insurer may use alternative computations for projected losses other than those specified in sections 2644.5 through 2644.7. In addition, alternative relating to the §2642.6 recorded period are now available. These revisions address the concerns voiced in the comment.

Commentor: James Hurley; on behalf of California Association of Professional Liability Insurers (CAPLI), September 12, 2006; page 2

Summary: In medical malpractice insurance there are significant time-lags between the occurrence and resolution of a claim. Therefore the three year 2642.6 recorded period does not allow for enough experience to be actuarially reasonable.

Response: Section 2642.6 has been revised to address the concern expressed in this comment.

Commentor: James Hurley; on behalf of California Association of Professional Liability Insurers (CAPLI), September 12, 2006; page 2 – 3

Summary: While there is a variance in section 2644.27 relating to loss development and trend, this approach allows for third party intervention which leads to costs and delays.

Response: California Insurance Code Section 1861.10(a) allows any person to initiate or intervene in (among other proceedings) any rate proceeding. The fact that the variance section recognizes this fact is consistent with existing California law. Third-party intervention is explicitly permitted by Proposition 103.

Commentor: Russina Sgoureva; Progressive West Insurance Company, September 13, 2006; page 3

Summary: Motorcycle insurance should be a separate line of insurance. It should not be a component of private passenger auto. This will eliminate the requirement that motorcycle insurers use Fast Track data for the credibility analysis associated with loss trend. Fast Track data does not include data related to motorcycle losses

Response: In response to this and similar comments the proposed regulations were revised. It is no longer required that motorcycle insurers use Fast Track data in the credibility analysis associated with loss trend. See section 2644.7(c).

Commentor: Russina Sgoureva; Progressive West Insurance Company, September 13, 2006; page 3.

Summary: Motorcycle insurance should be a separate line of insurance instead of it being a component of private passenger auto. Premium for motorcycle insurance is less than a third of the average premium for auto insurance and the acquisition costs generally

higher. Unless motorcycle is treated as a separate line insurers will be prevented from recovering legitimate and necessary expenses associated with this line of business by application of the efficiency standard.

Response: In response to this and similar comments a variance has been added to address this problem. Proposed section 2644.27 (f)(3)(C) provides that an insurer is allowed a higher or lower efficiency standard due to significantly smaller or larger than average policy size. This variance should be applicable to motorcycle insurance policies. Additionally, the Commissioner notes that California Insurance Code Section 660(a)(3) includes motorcycle coverage in the definition of an automobile policy. Furthermore, the National Association of Insurance Commissioners considers motorcycle insurance to be part of the automobile insurance line, which impacts a number of considerations, including various filing requirements. To remain consistent with the treatment of motorcycle insurance among the other states and the NAIC, the Commissioner declines to treat motorcycle insurance as a separate line for purposes of these regulations.

Commentor: Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 5.

Summary: The addition of product liability as a specialty line is appropriate. The classification of mechanical breakdown as other liability occurrence is consistent with the nature of that coverage. Medical malpractice should be classified as a specialty line.

Response: To the extent the comment supports the proposed regulations, a response is not required. As to medical malpractice, please see responses to similar comments elsewhere in this rulemaking file. The regulations have been revised with respect to their treatment of medical malpractice.

Commentor: Timothy J. Shannon, Jr.; California Association of Professional Liability Insurers (CAPLI), September 12, 2006; page 1 – 2.

Summary: Medical malpractice should be treated as a specialty line. The rationale behind the decision to remove medical malpractice from specialty lines should be made public.

Response: Even though medical malpractice and professional liability have not been restored into the specialty lines category, in response to this and similar comments a number of revisions have been made. One of the reasons frequently cited for restoring professional liability and medical malpractice into specialty lines is different treatment relating to projected losses. The regulations have been revised to address these concerns. Pursuant to proposed section 2644.4(d) for professional liability and errors and omissions coverage, the insurer may use alternative computations for adjusting projected losses other than those specified in sections 2644.5 through 2644.7. Changes were originally proposed to the treatment of medical malpractice coverage to address issues raised regarding Death, Disability, and Retirement ("DD&R") in response to a decision following a medical malpractice prior approval rate hearing.

Commentor: Jeff Donaldson, Devin O'Brien, Hillary Rowen; Supplemental Comments by The Doctors Company, September 13, 2006; page 1.

Summary: The proposed regulation does not treat medical malpractice as a specialty line. The rationale given by CDI provides that treatment of medical malpractice as a specialty line is not needed because "unique issues related to medical malpractice are separately addressed." This statement appears to refer to the new language in section 2644.4(d), which states: "For policies providing death, disability and retirement coverage, the projected losses for this coverage shall be calculated using a sound actuarial method."

Response: The regulations have subsequently been revised. Even though medical malpractice and professional liability have not been restored into the specialty lines category, in response to this and similar comments a number of revisions have been made. One of the reasons frequently cited for restoring professional liability and medical malpractice into specialty lines involves various alternative calculations s relating to projected losses. The regulations have been revised to address these concerns. Pursuant to proposed section 2644.4(d) for professional liability and errors and omissions coverage, the insurer may use alternative computations for adjusting projected losses other than those specified in sections 2644.5 through 2644.7.

Commentor: Jeff Donaldson, Devin O'Brien, Hillary Rowen; Supplemental Comments by The Doctors Company, September 13, 2006; page 1.

Summary: Specialty lines are subject to alternative calculations. Section 2644.4(e) provides that specialty lines losses need not be trended and adjusted pursuant to 2644.5 through 2644.7, but may be subject to an alternative computation. Section 2644.8 allows an alternative calculation of defense and cost containment expenses for specialty line. Both alternative computations must be actuarially sound.

Response: This is a general comment summarizing the regulatory provisions and does not suggest changes to the proposed regulations. As such, a specific response is not required.

Section 2643.2 Rating Basis

In response to comments, the October 5, 2006, version of these regulations deleted this section. The Commissioner has determined that deleting the description of rating basis as it appears in the current regulation is reasonable and prudent. These changed were made due to the experience gained in years of case-by-case determinations and in response to comments and suggestion made by insurers and others in connection with the review of various rate applications and during this rulemaking and /or in the previous workshops

Commentor: Shawna Ackerman, Pinnacle Actuarial Resources, Inc., on behalf of ACIC, PIFC, AIA; September 13, 2006; page 9 – 10;

Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 10.

Summary: It is not clear what purpose the second sentence of this section serves, and it is unclear why this section is needed at all.

Response: This section is now proposed for deletion.

Commentor: Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 5.

Summary: The insurer should have the option of using a different rating basis where appropriate and the Department should be able to approve or disapprove that selection in the context of rate review.

Response: This section is now proposed for deletion.

Section 2643.6 Interjurisdictional Allocations

Commentor: Shawna Ackerman, Pinnacle Actuarial Resources, Inc., on behalf of ACIC, PIFC, AIA; September 13, 2006; page 10;
Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 10 - 11

Summary: This section specifies that certain data shall be submitted and shall be used. However, subsequent sections supplant or ignore the data. For example, sections 2644.12 and 2644.21 replace the submitted data with industry average data. This section lacks clarity and consistency.

Response: Section 2643.6 provides that where reliable data exist for California losses, defense and cost containment expenses, ancillary income, commissions, state premium taxes, loss reserves, and unearned premium reserves, those data shall be used. The commentor indicates that sections 2644.12 and 2644.21 replace the submitted data with industry average data. However, the cited sections do not necessarily replace the submitted data. For example, if an insurer does not exceed the efficiency standard, the efficiency standard does not limit an insurer's expenses. The Commissioner rejects the comment. Read in context, the sections are clear and consistent.

Commentor: Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 5

Summary: This section is not significantly different from the provision used to determine rollbacks.

Response: No specific response is required.

2643.8 Factors Calculated by the Commissioner

Commentor: Milo Pearson and Christian Rataj, on behalf of the Pacific Association of Domestic Insurance Companies (PADIC) /National Association of Mutual Insurance Companies (NAMIC); September 12, 2006; page 3.

Summary: The 45-day publication provision should be increased to 90 days so that insurance carriers have ample opportunity to thoroughly consider and utilize the new factors.

Response: The Commissioner has determined that forty-five days notice is sufficient. Forty-five days represents more than ample time to prepare a rate filing, especially considering many insurers update rate indications, in all lines, on a regular basis.

Commentor: Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 5 – 6

Summary: This new section provides that rate applications shall use the most recent values calculated provided they were published at least 45 days before the submission of the application to the Department, which may be 45 days after the data underlying the Department determined input values become available. The requirement that a set of values cannot be used unless the filing was made more than 45 days after the publication of the input values does not have an obvious purpose. No rationale for precluding use of the most recently promulgated values is set forth.

If the Commissioner fails to publish the values, the application will be reviewed performing the calculations in the manner set forth in the regulations and applied to the rate application. But in that case the insurer needs to be able to generate the values provided by the regulations. However, in some cases there is insufficient information to generate the required numbers.

Response: The intent behind the 45 day notice period is to allow insurers a reasonable amount of time to prepare rate applications knowing what the new calculations will be. The Commissioner believes that insurers are entitled to know what values will be applied in review of their rate applications sufficiently in advance to allow them to consider those values in preparing their applications, if they choose to do so. The Commissioner does not want to create a system whereby, for example, an insurer prepares and submits a rate application, only to learn that the Department published new numbers 20 days later which it intends to use in reviewing the recently-submitted rate application.

In response to comments such as these indicating that in some cases the insurer will have insufficient information to generate the required numbers, on October 5, 2006, the Commissioner provided additional information about the manner in which the calculations are performed.

Section 2644.2 Maximum Permitted Earned Premium

Commentor: Mary B. Gaillard, on behalf of AIG, September 12, 2006, page 2.

Summary: The efficiency standard effectively caps an insurer's underwriting expenses for a program, unless an efficiency standard variance is applicable.

Response: The subject matter of this comment is discussed in detail in the response to comments relating to 2644.12 efficiency standard.

Commentor: Mary B. Gaillard, on behalf of AIG, September 12, 2006, page 2.

Summary: The maximum permitted earned premium for a program should be based on the program's maximum underwriting expenses, which may not be accounted for due to the use of industry averages, in the efficiency standard, for some expenses. This could result in inadequate rates.

Response: The maximum permitted earned premium factor is based company-specific projected losses, company-specific DCCE, company-specific ancillary income and company specific investment income. While it is true that the efficiency standard does apply industry averages for certain expenses in some circumstances, most of the expenses factored into the calculation of the maximum permitted earned premium are company-specific.

The regulations are designed to look at a rate application and determine whether the rate requested falls within the zone of reasonableness expected to allow the reasonably efficient insurer the opportunity to earn a fair rate of return. Therefore the regulations must attempt to define what is or is not reasonably efficient, among other things.

The Commissioner may not approve a rate that is inadequate. The regulations are designed to test for the adequacy or inadequacy of the rate. Any insurer who believes the ratemaking formula results in an inadequate rate may be eligible for a variance or may request a hearing to justify its requested rate.

Commentor: Pamela Pressley, on behalf of the Foundation for Taxpayer and Consumer Rights (FTCR); September 13, 2006, page 4;
Allan I. Schwartz, on behalf of FTCR, September 13, 2006, pages 2, 7-8.

Summary: The Commissioner has eliminated the consideration of company specific expenses. The efficiency standard is flawed. Projected fixed expenses have been eliminated.

Response: To the extent the comments refer to the efficiency standard, please see the Commissioner's responses to the comments set forth in connection with the efficiency standard regulation, section 2644.12. As further discussed elsewhere in this rulemaking file, the changes proposed to this section and to section 2644.12 are designed to clarify

what has come to be misunderstood language in the existing regulations. The reference to projected fixed expenses in this section has been deleted, recognizing that a better-than-average-efficiency insurer benefits from use of the efficiency standard.

Commentor: Milo Pearson and Christian Rataj, on behalf of the Pacific Association of Domestic Insurance Companies (PADIC) /National Association of Mutual Insurance Companies (NAMIC); September 12, 2006; page 3.

Summary: We oppose an "efficiency standard" in lieu of fixed and variable expense because (a) there is no mechanism in place to ensure that the "efficiency standard" set by CDI is not arbitrary and inconsistent with the actual business realities of many insurers; (b) the "efficiency standard" could hurt small insurance carriers, domestic carriers, and regional carriers that do not benefit from the scale of economy that larger national carriers can use to allocate and distribute expenses. This could result in an "unequal playing field" for smaller carriers and domestic carriers; (c) it could have a chilling effect upon corporate research and development of new insurance products and the marketing of products to underserved communities in the state; and (d) by requiring carriers to adjust their established underwriting, claims, and sales practices to conform to an "efficiency standard," certain carriers may have to reduce the quality and quantity of business services provided to consumers. This could result in underwriting and claim-settlement delays, which would be to the detriment of consumers.

Since "defense and cost containment" have replaced "allocated loss adjustment expenses (ALAE)" in the Earned Premium, we request that CDI clarify and define what specific costs and expenses are covered under the definition of "defense and cost containment."

Response: These comments are primarily directed at the efficiency standard set forth in section 2644.12. The Commissioner incorporates in response to these comments his responses set forth in connection with comments on section 2644.12. The Commissioner notes that the comment generally opposes the concept of an efficiency standard. However, the currently regulations, which were upheld by the Supreme Court in the *20th Century* case already provide for an efficiency standard. The existing regulations provide that the efficiency standard shall be set separately for each insurance line and at the weighted mean (by earned premium) expense ratio of insurers in that category. The proposed regulations continue that concept. Therefore, these comments are actually directed at the existing regulations, not at changes proposed to the existing regulations. A specific response is therefore not required.

Section 2644.8 describes "defense and cost containment expenses." As described in this rulemaking file, that terminology has been adopted by the NAIC and it is used for numerous reporting purposes by insurers. It is a commonly understood term in the insurance industry and the regulations use it as such. Therefore, there is no need to provide clarification of the term here.

Commentor: Richard J. Roth, Jr., Bickerstaff, Whatley, Ryan & Burkhalter, Inc.; September 11, 2006; page 1.

Summary: The proposed equation is an unusual variation of the basic ratemaking equation. Conceptually, it attempts to show the discounted losses and expenses in the numerator and investment income on unearned premiums and surplus in the denominator. However, it is not true that there is always investment income on the loss and expense reserves, the unearned premium reserve, and the surplus. The sum of these is often less than the invested assets, since a large amount of assets are usually in non-earning receivables from agents or reinsurers.

Response: The commentor's concern is addressed in section 2644.20(f). The yield is reduced by the ratio of invested assets to reserves.

Commentor: Richard J. Roth, Jr., Bickerstaff, Whatley, Ryan & Burkhalter, Inc.; September 11, 2006; pages 1 – 2.

Summary: The efficiency standard, investment income factors, and maximum profit factors are based on averages, not maximum or minimum amounts. If averages are included in an equation, earned premium is an average.

Response: The Commissioner has determined that, as the formula is applied, earned premium is not an average. However, to the extent the comment is actually directed to the efficiency standard, the investment income factors, and the profit factors, the comment is directed to unchanged portions of the regulations and a specific response is not required. For example, the comment indicates the maximum profit factor is based on an average. The only change made to the maximum profit factor language in section 2644.15(a) is the addition of the word "underwriting" before "federal income tax factor."

With that said the regulations are designed to look at a proposed rate change and determine whether the rate requested falls within the zone of reasonableness expected to allow the reasonably efficient insurer the opportunity to earn a fair rate of return. Therefore the regulations must attempt to define what is or is not reasonably efficient, among other things. As such a limited number of factors are based on industry averages. There is nothing new or novel in this type of ratemaking approach and it was specifically upheld in the *20th Century* decision.

Commentor: Richard J. Roth, Jr., Bickerstaff, Whatley, Ryan & Burkhalter, Inc.; September 11, 2006; page 2

Summary: The equation should be replaced by individual ranges for efficiency standard, investment income, and profit. The range should be at the 90th percentile about the average.

Response: This comment is directed to unchanged portions of the regulations, as discussed above, and a specific response is not required. The Commissioner incorporates herein by this reference his response to the previous comment.

Commentor: Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 6

Summary: The output of the calculation is likely to serve as a "binding variable" when either (1) the insurer's non-DCC expenses are higher that the prescribed efficiency standard (2644.12) or (2) the insurer's required rate of return is higher than that prescribed in 2644.16(a). Absent appropriate variances, the binding constraints set forth in this section could introduce inefficiencies into the California insurance market.

Response: The comment is speculative. To the extent certain "variables" in the formula apply imputed numerical factors based on industry average, in the case of rate regulation there is nothing inappropriate. However, the regulations are designed to determine whether an insurer's proposed rates fall within a zone of reasonableness. The rates within this zone allow a reasonably efficient insurer the opportunity to earn a reasonable rate of return. As to introducing inefficiencies into the California insurance market, the regulations are designed to promote efficiencies. Speculation as to future market inefficiencies brought on by application of this regulations are merely speculation. If such inefficiencies were likely to occur, they would have occurred already as the proposed regulations are a codification of procedures in place and applied for a number of years.

As to the comment regarding the need for variances, the regulations do recognize a significant number of variances.

Section 2644.3 Minimum Permitted Earned Premium

Commentor: Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 6

Summary: The calculated earned premium is binding only at the minimum rate of return allowed in 2644.16(b). Comments similar to those made in connection with section 2644.2 are made here.

Response: To the extent the comments mirror the comments made regarding section 2644.2, the Commissioner incorporates herein by this reference his responses to the similar comments made in connection with section 2644.2. Existing section 2644.1, which is not proposed for change in this rulemaking proceeding, provides that no rate shall be below the minimum permitted earned premium. To the extent the comment is simply recognizing that the minimum permitted earned premium represents the bottom of the range of reasonable rates, a specific response is not required.

Commentor: Milo Pearson and Christian Rataj, on behalf of the Pacific Association of Domestic Insurance Companies (PADIC) /National Association of Mutual Insurance Companies (NAMIC); September 12, 2006; page 3.

Summary: The comment refers to the comments made pursuant to Section 2644.2, above.

Response: Please see the response above. No further response is required.

Commentor: Richard J. Roth, Jr., Bickerstaff, Whatley, Ryan & Burkhalter, Inc.; September 11, 2006; page 1

Summary: The comments made in this section were the same as those made pursuant to section 2644.2, directly above. The commentor reiterates the similar comment he made regarding section 2644.2, maximum permitted earned premium. The proposed equation is an unusual variation of the basic ratemaking equation. Conceptually, it attempts to show the discounted losses and expenses in the numerator and investment income on unearned premiums and surplus in the denominator. However, it is not true that there is always investment income on the loss and expense reserves, the unearned premium reserve, and the surplus. The sum of these is often less than the invested assets, since a large amount of assets are usually in non-earning receivables from agents or reinsurers.

Response: The commentor's concern is addressed in section 2644.20(f). The yield is reduced by the ratio of invested assets to reserves.

Commentor: Richard J. Roth, Jr., Bickerstaff, Whatley, Ryan & Burkhalter, Inc.; September 11, 2006; page 1 -- 2

Summary: The comments made in this section were the same as those made pursuant to section 2644.2, directly above. As with maximum permitted earned premium, the efficiency standard, investment income factors, and maximum profit factors are based on averages, not maximum or minimum amounts. If averages are included in an equation, earned premium is an average.

Response: Please see response to similar comment above. No further response is required.

Commentor: Richard J. Roth, Jr., Bickerstaff, Whatley, Ryan & Burkhalter, Inc.; September 11, 2006; page 2

Summary: The comments made in this section were the same as those made pursuant to section 2644.2, directly above. The equation should be replaced by individual ranges for efficiency standard, investment income, and profit. The range should be at the 90th percentile about the average. A similar comment was made regarding maximum permitted earned premium.

Response: As indicated above, no further response is required. The responses to the previously-made comments are incorporated herein.

Section 2644.4 Projected Losses

The term "losses" as it is used in the ratemaking formula corresponds with "projected losses" § 2644.4 as adjusted pursuant to proposed §§ 2644.5, 2644.6, 2644.7.

It is the nature of the insurance industry to indemnify losses. At its most basic, insurance ratemaking is the process of projecting historical experience into the future. In order to calculate reasonable insurance rates historical data is used to predict trends in premium, losses and expenses. Historical data is also used to project the future costs associate with the transfer of risk and all that entails. In looking at historic and current experience and projecting it forward, the insurer, and the regulator must make various assumptions about rate and value changes, various trends and the historical and current costs of running the insurance operation. So too must various adjustments be made to historical data to insure the best and most credible rate change results from this process.

This section provides an explanation of how the regulations treat projected losses. The insurer's historical losses per exposure are to be adjusted by a catastrophe adjustment, (2644.5) by loss development, (2644.6) and by loss trend (2644.7)

Commentor: Mary B. Gaillard, on behalf of AIG, September 12, 2006, pages 2-3.

Summary: The use of earthquake modeling in the earthquake line is appropriate. The regulations should allow for use of catastrophe modeling for private passenger auto comprehensive lines due to significant earthquake exposure in this line.

Response: The Commissioner agrees that the use of earthquake modeling in the earthquake line is appropriate and the proposed regulations have been amended accordingly. At this point, the Commissioner has not determined that expanding use of catastrophe models beyond the lines currently proposed is appropriate.

Commentor: William K. Johanneson, on behalf of Farmers Insurance Group, September 13, 2006, pages 1- 2.

Summary: The use of earthquake modeling in the earthquake line is appropriate. The regulations should allow for use of catastrophe modeling for private passenger auto personal auto comprehensive lines, and for losses related to brush fire, wind/hail, and tornado losses. We recommend that the regulation be flexible enough to permit use of such models for other perils.

Response: The Commissioner agrees that the use of earthquake modeling in the earthquake line is appropriate. Please see response to similar comment above, which is incorporated herein by this reference.

Commentor: William K. Johanneson, on behalf of Farmers Insurance Group, September 13, 2006, pages 1-2.

Summary: The "preponderance of the evidence" relating to earthquake models is not appropriate.

Response: The Commissioner rejects this comment. California Insurance Code Section 1861.05(b) provides that the applicant shall have the burden of proving that the requested rate change is justified and meets the requirements of this article. The regulation merely clarifies that this provision applies equally for losses derived from a model, so there is no question about this issue. The Commissioner does not have authority to modify the evidentiary burden set forth in the statute. As such, the Commissioner does not have the authority to provide that any model used by the California Earthquake Authority is acceptable. The Commissioner also notes that existing regulation section 2646.5 provides that the insurer has the burden of proving, by a preponderance of the evidence, every fact necessary to show that its rate complies with all applicable law.

Commentor: Allan I. Schwartz, on behalf of FTCR, September 13, 2006, page 3.

Summary: Allowing for the use of computer models for the earthquake and fire following earthquake hazards are reasonable. However, there should be full disclosure of the model and all the assumptions underlying the model. The regulation should mirror the Florida statute in this regard. The model should be tested against actual historical data.

Response: The Commissioner believes the burden of proof provisions of California Insurance Code Section 1861.05(b) and the language proposed for this section address the commentor's concerns. Adopting the referenced provisions of Florida law as a California regulation is not necessary. Consequently, the Commissioner is not proposing changes to the regulations to mirror the Florida statutes.

Commentor: Randall Farwell, on behalf of the Interinsurance Exchange of the Automobile Club; September 13, 2006; page 3.

Summary: The regulations specifically allow for the use computer models for projecting losses from earthquake and fire following earthquake. There is no language in the regulation specifically allowing the use of models in other lines. This suggests that such models are not allowed to be used except where specifically mentioned. These models should be allowed for all lines of business and coverage perils.

Response: Please see response to similar comments above, which the Commissioner hereby incorporates by this reference.

Commentor: Richard J. Roth, Jr., Bickerstaff, Whatley, Ryan & Burkhalter, Inc.; September 11, 2006; page 2

Summary: Subsection (f) indicates that the burden of proof is on the applicant, which is an impossible burden in an earthquake rate filing. Testimony in prior cases has been inconclusive, and modeling firms do not predict the same results. At a minimum, the section should provide that any model used by the California Earthquake Authority is acceptable. The subsection should be deleted, or limited to the first sentence only.

Response: California Insurance Code Section 1861.05(b) provides that the applicant shall have the burden of proving that the requested rate change is justified and meets the requirements of this article. The regulation merely clarifies that this provision applies equally for losses derived from a model, so there is no question about this issue. The Department does not have authority to modify the evidentiary burden set forth in the statute. For similar reasons, the Department cannot simply provide that any model used by the California Earthquake Authority is acceptable.

Commentor: Shawna Ackerman, Pinnacle Actuarial Resources, Inc., on behalf of ACIC, PIFC, AIA; September 13, 2006; page 10 – 11;
Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 11.

Summary: Allowing models is an improvement, but they should be allowed for other perils as well, such as through a certification process similar to the Florida Hurricane Commission or use of models which have been specifically peer reviewed. The failure to allow for other models is arbitrary and not based on any reasoning, study, analysis, or justification. This section lacks consistency and it is unclear why the provision limits the models to which it should apply.

Response: The Commissioner has determined that at this time use of earthquake modeling in the earthquake line, and for fire following earthquake, is appropriate. To the extent this comment is directed at use of models for other perils, ti is beyond the scope of the changes proposed in this rulemaking proceeding and a specific response is not required.

Commentor: Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 7.

Summary: Comments are made regarding medical malpractice coverage.

Response: Please see responses to similar comments made elsewhere in this rulemaking file.
Commentor: Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 7.

Summary: The percentage of housing in high risk areas has expanded significantly. Therefore, long term catastrophe loss data may not be a good predictor of current risk exposure. Historical loss data may need to be supplemented by catastrophe models.

Response: Using a multi-year long term historical average of catastrophe claims is standard actuarial practice, is the standard set forth in the existing regulations, and is not proposed for change in this rulemaking proceeding. However, in response to this and similar comments the commissioner has determined that catastrophe models are appropriate for use in relation to earthquake and fire following earthquake coverages.

The Commissioner would note that while it maybe true that the percentage of housing in higher risk areas has expanded in recent years a substantial number of building code changes relating to building materials and construction methods have been implemented in these "higher risk" areas. Other safety measures relating to brush clearance, fire fighter access and access to water have also been implemented. These measures have already had a substantial impact on catastrophe losses in California. The commentor provides no convincing evidence that long term catastrophe loss data may not be a good predictor.

Commentor: Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 7.

Summary: The proposed regulation provides that the applicant bears a specified burden with respect to the model, but it is unclear how the insurer will satisfy the burden, absent a hearing.

Response: The burden of proof provisions are set forth in Proposition 103 and have been applicable since that initiative was passed by the voters in 1988. The provision will continue to be implemented as it has been since it was upheld by the Supreme Court in the *CalFarm* decision.

Commentor: Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 7.

Summary: Questions arise as to whether the Department will hold a hearing on every earthquake rate filing. CDI should preapprove earthquake models for all insurers to use. Most non-CEA companies, who would bear the burden of proving the earthquake models, are small companies. At a minimum, the regulations should provide that an insurer can use an earthquake model that has already been approved in the context of a CEA filing. The insurer would only have to demonstrate the application of the CEA model is appropriate.

Response: The comment evidences a misreading of the proposed regulations. The regulations are not intended to and do not require a hearing on every earthquake filing.

California Insurance Code Section 1861.05(b) provides that the applicant shall have the burden of proving that the requested rate change is justified and meets the requirements of this article. The regulation merely clarifies that this provision applies equally for rate applications using model, so there is no question about this issue. The Commissioner does not have authority to modify the evidentiary burden set forth in the statute. As such,

the Commissioner does not have the authority to provide that any model used by the California Earthquake Authority is acceptable.

Section 2644.5 Catastrophe Adjustment

The term "losses" as it is used in the ratemaking formula corresponds with "projected losses" § 2644.4 as adjusted pursuant to proposed §§ 2644.5, 2644.6, 2644.7. The Catastrophe adjustment is the first of the three adjustments made to losses.

The Catastrophe adjustment is a standard and universally accepted ratemaking adjustment. The catastrophe adjustment is necessary to prevent infrequent but unusually pronounced spikes in claims costs due to catastrophes from skewing future projections. A process must be in place to adjust for the impact of sudden and substantial increases in loss costs due to catastrophe.

In the terminology of the insurance industry, catastrophes are "low frequency, high severity" events. Low frequency refers to the relatively rare nature of catastrophic occurrences. High severity refers to the unusually high loss costs that are associated with catastrophes. Catastrophe losses can cause extreme volatility in historical data due to the severity – in terms of claims dollars paid out – associated with these events. Indeed, it is the unusually large aggregate losses associated with an event that make that event a catastrophe for ratemaking purposes. Because of the unusual nature of these types of losses catastrophe losses must be adjusted to lessen the anomalous impact these rare but costly events would have in the ratemaking process. Unless catastrophe data is "smoothed" – spreading the aggregate loss out over a number of years -- the rate indication based upon catastrophe losses will be skewed and incorrect.

Commentor: William K. Johanneson, on behalf of Farmers Insurance Group, September 13, 2006, pages 1, 3.

Summary: The requirement to use at least a 21- and 39-year average catastrophe factor for homeowners is arbitrary and they are not theoretically appropriate periods upon which to base a prospective catastrophe measure. Rather than specify a period over which to average catastrophes, insurers should be allowed the flexibility to set the period of time to be used for the catastrophe adjustment.

Response: In response to this and other similar comments the language in the proposed section was modified. In the latest revision the number of years over which the catastrophe losses shall be smoothed for homeowners is "at least 20 years," which represents a standard actuarial practice.

The Commissioner has determined that catastrophe adjustment is an essential factor in the ratemaking process. He is well within his authority to establish the minimum number of years to be used in the smoothing process. For most lines, the Commissioner does allow the insurer flexibility to determine a catastrophe adjustment. The applicable number of years is set only for homeowners and private passenger automobile physical

damage. Additionally, there is no catastrophe adjustment for private passenger auto liability. Simply allowing insurers the flexibility to set the time period they will use for those common personal lines does not provide sufficient guidance as to what the Commissioner will consider appropriate and is likely to lead to unnecessary disagreements as to whether a proposed rate falls within the range of reasonableness. Without a standard, it is difficult for the Commissioner to ensure that the rates he approves are not excessive.

Commentor: William K. Johanneson, on behalf of Farmers Insurance Group, September 13, 2006, page 3.

Summary: The typical catastrophe loss experience of an individual insurer may not necessarily be reflective of the total catastrophic exposure to loss appropriate for ratemaking purposes. We therefore recommend that the regulations be modified to provide sufficient flexibility to allow for appropriate recognition of the potential for catastrophic events that are significant yet not frequent enough to be reflected in the individual insurer's own historical experience.

Response: In response to this and similar comments made both during the technical workshops and during this rulemaking, the regulations have been revised. Smaller companies may lack the data sufficient to perform the required calculations. Larger insurers may likewise be affected depending on the line of business. In response to this comment the proposed section now provides that where an insurer lacks sufficient data, the insurer's data may be "supplemented by appropriate data." The proposed language explicitly provides that the catastrophe adjustment shall reflect any changes in mix of business.

Commentor: Foundation for Taxpayer and Consumer Rights; September 13, 2006; Allan I. Schwartz, on behalf of FTCR, September 13, 2006, page 4.

Summary: It is unclear why the regulation requires different time periods to analyze the catastrophes from homeowners multiple peril fire and homeowners multiple peril wind, or if catastrophe data are even available split in this manner.

Response: In response to this and similar comments the distinction relating to fire and wind has been eliminated.

Commentor: Foundation for Taxpayer and Consumer Rights; September 13, 2006; Allan I. Schwartz, on behalf of FTCR, September 13, 2006, page 4.

Summary: Longer time periods of information should be available. The use of longer time periods will allow for a more accurate and stable calculation of the catastrophe adjustment. The time period used for the catastrophe adjustment for homeowners insurance should be at least 40 years.

Response: The regulations have been amended and now provide that the number of years shall be at least 20 for homeowners multiple peril. This is standard actuarial practice.

As to the suggestion of a forty-year requirement, the Commissioner has determined that a minimum of 20 years for homeowners multiperil is sufficient and actuarially reasonable. Use of a 40-year period may not accurately reflect the impact of the losses.

Commentor: Foundation for Taxpayer and Consumer Rights; September 13, 2006; Allan I. Schwartz, on behalf of FTCR, September 13, 2006, page 4.

Summary: The regulation does not deal with how to handle catastrophes for personal lines wind coverage that is not part of homeowners insurance. The use of a longer time period will allow for a more accurate and stable calculation of the catastrophe adjustment. The time period used for the catastrophe adjustment for personal lines non-homeowners wind should be at least 50 years.

Response: The proposed regulations establish specific time periods applicable to homeowners multiple peril fire and private passenger automobile physical damage. Catastrophe adjustments are not recognized for private passenger automobile liability. Beyond this, the regulations provide that the catastrophe adjustment shall be based on a multi-year long-term average. The Commissioner has determined that this is the most appropriate manner in which to handle catastrophe adjustments. The Commissioner disagrees that the catastrophe adjustment for personal lines non-homeowners should be at least 50 years.

Commentor: Allan I. Schwartz, on behalf of FTCR, September 13, 2006, page 5.

Summary: The regulation does not specify how catastrophes are to be defined

Response: Catastrophe is defined in the statistical agents or advisory organizations reporting rules and in standard actuarial literature. The fact that the regulations do not contain a specific definition of catastrophe has not resulted in any problems since adoption of the regulations in 1991. This portion of the comment is directed at an unchanged portion of the regulations and a more specific response is therefore not required.

Commentor: Allan I. Schwartz, on behalf of FTCR, September 13, 2006, page 5.

Summary: This proposed amended section also requires an insurance company to: (i) supplement its own catastrophe data, where it does not have enough data, with the experience from the more recent Insurance Services Office filing and (ii) adjust for any change between the historical and prospective exposure to catastrophe due to a change in the mix of business. However, no direction is given for either of these requirements. This will result in different insurers using varying procedures.

Response: The ISO data requirement has been eliminated.

While it may be at times desirable to be more specific than not about the treatment of loss data, in the case of the catastrophe adjustment and in response to comments, the Commissioner has opted for flexibility. Given the logistical difficulties inherent in augmenting company data the Commissioner has determined it is reasonable that some flexibility be allowed. In any event, any augmentation of data would be subject to a test of the actuarial reasonableness of the methodology employed.

Commentor: Randall Farwell, on behalf of the Interinsurance Exchange of the Automobile Club; September 13, 2006; page 4.

Summary: The experience periods seem somewhat arbitrary but reasonable.

Response: The regulation has been revised from "at least 21 and 39 years: to "at least 20 years." The Commissioner has determined that for the purposes of consistency and in order to keep the job of insurance rate regulation manageable, the minimum number of years to be used in averaging catastrophe losses must be designated. The minimum number of years is not an arbitrary figure but one arrived at by the Commissioner's staff based on many years of case-by-case determinations and in accordance with standard actuarial principles. The Commissioner has relied on his expertise to designate the number. The Commissioner has determined that the catastrophe adjustment is an integral part of the ratemaking process.

To the extent the commentor supports the proposed regulation, a specific response is not required.

Commentor: Randall Farwell, on behalf of the Interinsurance Exchange of the Automobile Club; September 13, 2006; page 4.

Summary: We suggest that carriers be allowed to develop a catastrophe loading for auto liability, if data supports the calculation, even though auto liability has little or no catastrophe exposures at basic limits. At increased limits, data may support a catastrophe adjustment.

Response: The Commissioner has determined that a catastrophe adjustment should not be allowed for private passenger automobile liability. Insurers are sufficiently able to project their private passenger automobile losses pursuant to section 2644.4.

Commentor: Michael A. Walters, Towers Perrin, on behalf of the Association of California Insurance Companies; September 13, 2006; page 14 – 15.

Summary: There is no definition of catastrophe.

Response: Please see response to similar comment above.

Commentor: Michael A. Walters, Towers Perrin, on behalf of the Association of California Insurance Companies; September 13, 2006; page 14 – 15.

Summary: Personal auto liability appears to be excluded, which apparently prohibits use of increased limits ratemaking techniques.

Response: Please see response to similar comment above.

Commentor: Michael A. Walters, Towers Perrin, on behalf of the Association of California Insurance Companies; September 13, 2006; page 14 – 15.

Summary: Only a longer period of actual claims, not external data, apparently can be used. Actuaries supplement property catastrophes with non-insurance claim data. The primary measurement data base appears to be the insurer's own, but current actuarial techniques rely more on industry data for severity and non-insurer data for frequency. If the return period is more than 50 years, measuring changes in mix of business is problematic. Since catastrophes are excluded from loss development, it implies that this section does include liability large loss issues.

Response: As revised on October 5, 2006, the proposed regulation provides that the insurer's data shall be supplemented by appropriate data.

The regulation, as currently written, provides that in those insurance lines and coverages where catastrophes occur, catastrophic losses are replaced by a loading based on a multi-year, long-term average.

As with the current regulation, the proposed regulation provides that a longer time period of data can be used. The purpose of this regulation is to indicate that, for catastrophe losses, the losses of any one accident year are replaced by a long-term average. This is standard actuarial practice. Therefore, the comment on this portion of the regulations involves a comment on an unchanged portion of the regulations and a detailed response is not required.

The commentor notes that it may be difficult to measure changes in mix of business for a time period of more than 50 years. However, this section simply provides that the catastrophe adjustment shall reflect changes between the insurer's historical and prospective exposure to catastrophe due to a change in mix of business. This is an appropriate actuarial practice and recognizes that an insurer's losses may be different if its writings are different.
Therefore, the Commissioner has determined that a further response is not required.

Commentor: Richard J. Roth, Jr., Bickerstaff, Whatley, Ryan & Burkhalter, Inc.; September 11, 2006; page 2.

Summary: There is no need for the new catastrophe calculation language. Actuaries are capable of dealing with catastrophe exposure, which varies from insurer to insurer. The Insurance Services Office is not a good source of catastrophe data.

Response: This section recognizes actuarial judgment. The reference to the Insurance Services Office has been deleted, in response to this and other comments.

Commentor: Shawna Ackerman, Pinnacle Actuarial Resources, Inc., on behalf of ACIC, PIFC, AIA; September 13, 2006; page 11;
Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 12

Summary: The proposed number of years for the catastrophe adjustment generally will require reliance on ISO data but use of other data may be more relevant. This is arbitrary and not supported. It lacks consistency and authority. An alternate approach is not to specify the time period. Alternative language is suggested.

Response: The section has been amended and now provides that where the insurer does not have enough years of data, the insurer's data shall be supplemented by appropriate data. The reference to ISO has been deleted.

Commentor: Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 7 – 8.

Summary: The proposal requires at least 21 years for fire and 39 for wind for the catastrophe adjustment. But many insurers, especially those with small market shares, currently use combined fire and wind catastrophe loadings. They do not have enough company data to compute separate loadings for wind and fire. And many insurers use a shorter data period, typically 20 years.

Response: In response to this and similar comments the regulations have been amended in accordance with the comment.

Commentor: Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 7 – 8

Summary: Properly calculated, the historical catastrophe experience may be appropriate for the adjustment of historical data, as in loss development and trend, but may not be accurate for prospective expected catastrophe losses. California's dramatic population boom over the past 40 years must be considered. Many more people have moved to coastal and brush fire areas. Thus the catastrophe exposure has increased, so using old experience will not be representative of the current exposure and will produce inadequate indications. The use of catastrophe models may be essential.

Response: The regulation specifically provides that changes in mix of business which impact historical and prospective exposure are recognized.

As to the use of models, the Commissioner agrees that the use of earthquake modeling in the earthquake and fire following earthquake exposure is appropriate.

Section 2644.6 Loss Development

The term "losses" as it is used in the ratemaking formula corresponds with "projected losses" § 2644.4 as adjusted pursuant to proposed §§ 2644.5, 2644.6, 2644.7. Loss development is the second of three adjustments.

Prospective insurance ratemaking uses the history of past losses in an attempt to predict future losses, as accurately as possible. Put another way, in order to develop proper rates, rates must take into account, among other things, how much an insurer should expect to pay out in claims in the future. The proposed revisions enhance flexibility in a number of ways. The variance in § 2644.27(f)(9) addresses specifically conditions that may affect reporting and payment patterns

The current regulation provides that the Commissioner shall prescribe the number of reporting intervals to be used in determining the company specific loss development factor as a "generic determination." The proposed revision eliminates this "generic determination." The treatment of loss development in the proposed regulation enhances flexibility and will lead to more accurate results. Furthermore, this proposed section enhances flexibility by allowing insurers to apply policy-year and report-year data in addition to the accident-year approach in the current regulation.

The revision to this section also specifies that loss development be based on dollar-weighted average ratios rather than using a straight average. This change is designed to enhance accuracy. The Commissioner has determined that the dollar-weighted average, as opposed to straight average, will provide more accurate loss development factors.

In the current as well as the proposed regulation, loss development is a company-specific process in that the insurer's own loss data is used in the loss development process. The generic aspect of this factor, relating to a set number of reporting intervals prescribed by the Commissioner has been eliminated.

Commentor: Mary B. Gaillard, on behalf of AIG, September 12, 2006, page 3.

Summary: The restriction of loss development selections to simple paid and incurred methods may be too restrictive. This could potentially preclude a company from using the methodology utilized in company reserving practices, which could result in rates based on projected losses that are out of line with financial statements.

Response: The comment appears to be directed at unchanged portions of the regulation text. To that extent, a specific response is not required. In general, the changes proposed for this section are in accordance with standard actuarial practice and allow insurers additional flexibility. The comment is also speculative. The October 5,

2006, version of the regulations includes additional changes to this section. However, the Commissioner has determined not to further amend this section.

Commentor: Mary B. Gaillard, on behalf of AIG, September 12, 2006, page 3.

Summary: The requirement relating to "the dollar-weighted average of the ratios of losses for the three most recent accident years" is unduly rigid. One year, two year or five-year averages may be more appropriate based on individual insurer circumstances. A variance to address these loss development restrictions has been added to 2644.27.

Response: The revision to this section specifies that loss development be based on dollar-weighted average ratios rather than using a straight average. This change is designed to enhance accuracy. The Commissioner has determined that the dollar-weighted average, as opposed to straight average, will provide more accurate loss development factors. The "three most recent accident year" language is contained in the existing regulations. Therefore, the comment is directed at an unchanged portion of the regulation and a specific response is not required. However, the Commissioner notes that changes in the October 5, 2006, version of these regulations do allow for accident years, policy years, or report years. While it may be argued that proposed approach is "too restrictive," this new revision was designed to enhance flexibility. Additionally, as was correctly pointed out in the comment, a variance is available.

Commentor: William K. Johanneson, on behalf of Farmers Insurance Group, September 13, 2006, pages 1, 3.

Summary: The regulation requires specific methodologies be employed to develop losses. There are other methods that are actuarially sound. Changes in claims practices or other external forces can render the use of an average loss development factor to be inappropriate. The regulation should be amended to allow for flexibility to select any of actuarially recognized methods for loss development, without requirement of a variance.

Response: The comment is primarily directed at an unchanged portion of the regulations. To that extent, a specific response is not required. The loss development methodology set forth in the regulation is a standard actuarial methodology. It allows the insurer significant flexibility in presenting its calculations. Further amendments to this section set forth in the October 5, 2006, version allow additional flexibility. However, as the commentor notes, a variance is available. The Comment is rejected.

Commentor: Foundation for Taxpayer and Consumer Rights (FTCR); September 13, 2006;

Allan I. Schwartz, on behalf of FTCR, September 13, 2006, page 5; oral statement of Allan Schwartz (FTCR), September 13, 2006, transcript pages 48-49.

Summary: Insurers should not be allowed the choice of the loss development methodology. Allowing insurers to choose loss development methodology will cause an upward bias in rates. Insurers should be required to (1) use either paid or case incurred

loss development (2) use an average of paid and case incurred loss development or (3) make the regulation clear that the loss development method used by the insurer in the rate filing is not presumed to be reasonable. The burden of proof should be on the insurer to justify the loss development method

Response: Proposition 103 and the Department's existing regulations provide that an insurer has the burden to prove every fact necessary to demonstrate that its rate complies with all applicable legal requirements. Revisions to this section specifically require the insurer to demonstrate that its selection is the most actuarially reasonable. Although the regulation does allow insurers flexibility, contrary to the implication of this comment, this section of the proposed regulations does not set forth a free-for-all approach.

The loss development methodology allows for a choice of applying paid or case incurred loss development, whichever is the most actuarially reasonable. The Commissioner sees no utility in requiring an average of paid and case incurred loss development where the choice is subject to the most actuarially reasonable standard.

Commentor: Randall Farwell, on behalf of the Interinsurance Exchange of the Automobile Club; September 13, 2006; page 4.

Summary: The proposed regulation specifies that loss development must be based on the three most recent accident, policy or report year periods and only paid and "paid + case" (incurred) development methods are allowed. These narrow limitations restrict the actuary from selecting more appropriate methods based on their review of the historical claims data.

Response: As set forth in *Calfarm,* Proposition 103 requires no rate be excessive or inadequate. Some mechanism must be in place to allow the Commissioner to meet these requirements and to keep the job manageable. That mechanism is these regulations. The regulations are designed to provide a consistent methodology by which to review insurer calculated rates to see if they fall within the zone or reasonableness, that being, the range between excessive and inadequate.

The language in the revised version of this section was made in response to comments seeking enhanced flexibility. The regulation was further revised after the September public hearing and public comment period. The Commissioner rejects the belief that the regulation as presented is "too restrictive" On the contrary. The Commissioner has determined that this proposed section allows for maximum flexibility while preserving a methodology that will provide a reasonable level of consistency.

Additionally, the section 2644.27(f)(9) variance pertaining to loss development allows an insurer to present an alternative methodology for calculating loss development. The suggested methodology would be subject to scrutiny as to whether it is actuarially reasonable.

Commentor: Randall Farwell, on behalf of the Interinsurance Exchange of the Automobile Club; September 13, 2006; page 4

Summary: Insurers should be allowed to apply any loss development methodologies consistent with the Standards of Practice of the Casualty Actuarial Society. The proposed limitation is too restrictive and may often force unreasonable results. Changing environmental conditions may affect reporting and payment patterns, necessitating the use of other loss development techniques.

Response: The Commissioner has determined that loss development methodology on the proposed revisions is consistent with standard actuarial practice. The proposed regulation is essentially the same as the existing regulation. However, the proposed revisions enhance flexibility in a number of ways, as discussed elsewhere in this rulemaking file. To the extent the comment is objecting to the loss development method set forth in the existing regulations, the comment is not related to a proposed change in the regulations and a specific response is not required. The variance in section 2644.27(f)(9) addresses specifically conditions that may affect reporting and payment patterns. That variance was included in the regulation in response to this and similar comments.

Commentor: Michael A. Walters, Towers Perrin, on behalf of the Association of California Insurance Companies; September 13, 2006; page 15.

Summary: The fact that more than three accident years are intended to measure loss development should be clarified. Why exclude more than three observations of link ratios, especially for smaller insurers and those having books of business that require more stability in the measurement. A tail factor should be permitted for an insurer that only has offered a coverage for five or six years and its oldest accident year still shows development. For some longer tail commercial lines, straight incurred or paid development does not capture the volatility inherent in or the uncertainty in measuring ultimate liabilities. Appropriate adjustments to a paid or incurred method should be allowed.

Response: Language has been added in the October 5 version of these regulations which provides that where the loss development factors within a given line significantly vary by subline, by size of loss, or by coverage, separate loss development factors shall be calculated in accordance with that evidence. The variance set forth in section 2644.27(f)(9) also addresses the concerns expressed by the commentor.

Commentor: Shawna Ackerman, Pinnacle Actuarial Resources, Inc., on behalf of ACIC, PIFC, AIA; September 13, 2006; page 11 – 12;
Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 12

Summary: The definition is unclear and contradictory. The first sentence of the section states that loss development is the process by which reported losses are adjusted

for anticipated payout patterns. Reported losses consist of paid losses and case specific reserves. Payout patterns apply only to the paid portion of reported losses. A better definition would be that loss development is the process by which losses accumulate to their ultimate value.

Response: This comment relates to an unchanged portion of the regulation text. Therefore a specific response is not required. However, the Commissioner does not agree that the language is contradictory. This portion of the regulation was first adopted in 1991 and has not resulted in problems. Prospective insurance ratemaking uses the history of past losses in an attempt to predict future losses, as accurately as possible. Put another way, in order to develop proper rates, rates must take into account, among other things, how much an insurer should expect to pay out in claims in the future, i.e. "payout patterns." The comment is correct that case specific reserves are not "paid out" but that does not preclude recognizing the impact of and reserving patterns on future "payout patterns." The comment is rejected.

Commentor: Shawna Ackerman, Pinnacle Actuarial Resources, Inc., on behalf of ACIC, PIFC, AIA; September 13, 2006; page 12;
Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 12.

Summary: Deletion of the phrase "for as many reporting intervals as the Commissioner may prescribe" creates lack of clarity. It could be interpreted to mean that only the three most recent accident years will be allowed. The language instead should allow "for as many reporting intervals as is necessary to fully develop losses to their ultimate value."

Response: The revision to the language in the section was made in response comments by insurers and others over the past several years and is designed to enhance flexibility. This section now provides that loss development shall be presented as a loss-development triangle, based on the dollar-weighted average of the ratios of losses for the three most recent accident-years, policy-years, or report-years available for a reporting interval. In response to comments, the October 5 version also provides that where the loss development factors within a given line significantly vary by subline, by size of loss, or by coverage, separate loss development factors shall be calculated in accordance with that evidence, allowing additional flexibility. Additionally, the proposed regulations include a variance for loss development in section 2644.27(f)(9). Section 2644.27(f)(9)(B) makes it clear that development to ultimate value is allowed.

Commentor: James Hurley; on behalf of California Association of Professional Liability Insurers (CAPLI), September 12, 2006; page 3.

Summary: The approach set forth in section 2644.6 is too mechanized and will cause problems because the loss development factors are only applied to a three-year experience period. Projection uncertainty is far more significant in medical malpractice.

Response: In response to this comment and others like it, the regulations were revised. Pursuant to section 2644.4(d), sections 2644.5 through 2644.7 no longer apply to medical malpractice.

Commentor: James Hurley; on behalf of California Association of Professional Liability Insurers (CAPLI), September 12, 2006; page 3.

Summary: Medical malpractice has a much larger proportion of unpaid losses in the latest three years than other lines and coverages. This leads to elevated risk due to changes in reserving levels and claim closure rates. The variances address some of these issues but not all of them.

Response: In response to this comment and others like it, the regulations were revised. Pursuant to section 2644.4(d), sections 2644.5 through 2644.7 no longer apply to medical malpractice.

Commentor: James Hurley; on behalf of California Association of Professional Liability Insurers (CAPLI), September 12, 2006; page 3.

Summary: The proposed regulation makes no provision for layering losses for development purposes. Layering is a common actuarial practice.

Response: In response to this comment and others like it, the regulations were revised. Pursuant to section 2644.4(d), sections 2644.5 through 2644.7 no longer apply to medical malpractice.

Commentor: James Hurley; on behalf of California Association of Professional Liability Insurers (CAPLI), September 12, 2006; page 3.

Summary: The proposed regulation does not allow for different techniques for projection for the respective layers of loss considering their relative credibility and predictability.

Response: In response to this comment and others like it, the regulations were revised. Pursuant to section 2644.4(d), sections 2644.5 through 2644.7 no longer apply to medical malpractice.

Commentor: Jeff Donaldson, Devin O'Brien, Hillary Rowen; Supplemental Comments by The Doctors Company, September 13, 2006; page 4 – 5.

Summary: The proposed regulation in section 2644.6 is somewhat ambiguous. The section states: "Loss development may employ either paid losses or the sum of paid losses and case-specific reserves." Since loss development applies different factors to each of three individual report years, would a single development approach (e.g. paid) need to be used for all report years? Or could the paid method be used for some report years while the incurred (paid plus case reserve) method is used for the other report

years? Would the regulations allow for the judgmental selection of estimated losses that is within the range of the two methods?

Response: In response to this and similar comments the regulation has been amended and now provides that loss development shall employ either paid losses or the sum of paid losses and case-specific reserves.

Commentor: Jeff Donaldson, Devin O'Brien, Hillary Rowen; Supplemental Comments by The Doctors Company, September 13, 2006; page 5.

Summary: A strict formulaic approach to loss development will compromise the accuracy and stability of premium rates for medical malpractice. Changes in the rate of loss payout due to environmental or operational effects should be considered.

Response: In response to this and other similar comments, the regulations have been amended. Pursuant to section 2644.4(d), sections 2644.5 through 2644.7 no longer apply to medical malpractice.

Commentor: Jeff Donaldson, Devin O'Brien, Hillary Rowen; Supplemental Comments by The Doctors Company, September 13, 2006; page 5.

Summary: A strict formulaic approach to loss development will compromise the accuracy and stability of premium rates for medical malpractice. Operational effects that change the adequacy of case reserves should be considered.

Response: In response to this and other similar comments, the regulations have been amended. Pursuant to section 2644.4(d), sections 2644.5 through 2644.7 no longer apply to medical malpractice.

Commentor: Jeff Donaldson, Devin O'Brien, Hillary Rowen; Supplemental Comments by The Doctors Company, September 13, 2006; page 5.

Summary: A strict formulaic approach to loss development will compromise the accuracy and stability of premium rates for medical malpractice. Consideration of more than three prior years for a reporting interval, due to the volatile nature of the medical malpractice line of business, would be appropriate.

Response: In response to this and other similar comments, the regulations have been amended. Pursuant to section 2644.4(d), sections 2644.5 through 2644.7 no longer apply to medical malpractice. Please see section 2644.4(d).

Commentor: Jeff Donaldson, Devin O'Brien, Hillary Rowen; Supplemental Comments by The Doctors Company, September 13, 2006; page 5.

Summary: A strict formulaic approach to loss development will compromise the accuracy and stability of premium rates for medical malpractice. Other actuarial methods less dependent on the historical stability of loss development should be considered.

Response: In response to this and other similar comments, the regulations have been amended. Pursuant to section 2644.4(d), sections 2644.5 through 2644.7 no longer apply to medical malpractice. Please see section 2644.4(d).

Commentor: Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 8.

Summary: The proposal requires the dollar-weighted average, rather than a straight average, and states that the insurer can use either paid or paid plus case reserve data. It is unclear whether (1) the insurer must choose between using paid loss development factors or paid plus case reserve development factors, (2) the insurer can use paid or paid plus case for different years, or (3) the insurer can choose ultimate loss development factors in the range indicated by the paid and paid plus case reserves indications. The last would appear to be the most sensible. If the paid and paid plus case reserve development factors differ, the insurer may prefer to choose ultimate losses in the middle of the range, rather than selecting the high or low number.

Response: The regulation has been amended and now provides that the insurer shall submit both the factors and ultimate losses for both paid and incurred loss development reported claims and the paid claims calculations, and shall demonstrate that its selection is the most actuarially reasonable. Loss development data shall exclude catastrophes. Where the loss development factors within a given line significantly vary by subline, by size of loss, or by coverage, separate loss development factors shall be calculated in accordance with that evidence. It also provides that loss development shall employ either paid losses or the sum of paid losses and case-specific reserves.

The revision to this section specifying that loss development be based on the dollar-weighted average ratio was made in response to comments submitted during the workshop process. The Commissioner has determined that the dollar-weighted average, as opposed to straight average, will provide more accurate loss development factors.

Section 2644.7 Loss and Premium Trend

As stated above, the term "losses" as it is used in the ratemaking formula corresponds with "projected losses" section 2644.4 as adjusted pursuant to proposed sections 2644.5, 2644.6, 2644.7. Trending is the third of the three adjustments. In the current regulation loss trend is a generic determination. The proposed revision eliminates the generic aspect and now applies a company-specific approach using insurer data to tailor a company-specific the loss trend. Loss trend captures past and prospective changes in claim costs, claim frequencies and losses per exposure.

Premium trend has been incorporated into this section in keeping with standard loss ratio methodology and is also a company-specific process. Loss trend may also capture many of the changes in claims costs that are reflected in the premium trend.

Insurance ratemaking is the process of projecting historical experience into the future in an effort to predict as accurately as possible the future cost of the transfer of risk. Calculating the loss and premium trend is integral to the ratemaking process. This was recognized by the California Supreme Court in *20th Century. 20th Century,* 8 Cal. 4th 216, 250; 32 Cal. Rptr. 807, 828. In testing the rate application, the Commissioner will look at the insurer's historic and current losses and premiums, in an effort to identify and establish trends in losses and premiums and to project those costs into the future.

Due to the experience gained in many years of case-by-case determinations, in response to changes in the marketplace, and in response to comments and suggestion made over the past several years, the Commissioner has determined that this revision to the current regulation is reasonable, prudent and necessary. The specific purpose of deleting the generic determination of loss trend in favor of using company-specific data is to enhance flexibility, to ensure the characteristics of individual insurers are reasonably considered and achieve the most accurate results possible.

Commentor: Mary B. Gaillard, on behalf of AIG, September 12, 2006, page 3.

Summary: The process is too rigid because frequency trends are restricted to "closed claim" frequency data. The regulation should allow frequency trends to be based on incurred or paid (including partial payment) claim counts data as that data is more reliable for calculating frequency trends. Insurers should be allowed to select from 24 point, 12 point, 8 point, 6 point and 4 point fits. A proposed variance to address these restrictions has been added to Section 2644.27.

Response: In the current regulation loss trend is a generic determination. In an effort to enhance flexibility and in response to this and other similar comments the generic approach was eliminated. For frequency trend, in response to this and similar comments, the October 5, version of the regulations was revised and now allows insurers to use either reported or closed claims. Frequency trends are not limited to closed claim data.

Twelve quarters of rolling data is a widely accepted historical time frame to use in loss trending. In addition, years of experience gained in case-by-case determinations has led the Commissioner to determine that the use of 12 quarters of rolling data produces the most actuarially sound results.

With that said, a proposed variance relating to loss and premium trend is included in the variance section of the regulations, section 2644.7(f)(10). This variance was added in response to this and similar comments made during this rulemaking, the prior workshops and / or in connection with case-by-case determinations.

Commentor: Randall Farwell, on behalf of the Interinsurance Exchange of the Automobile Club; September 13, 2006; pages 2, 4.

Summary: The complement of credibility for private passenger auto loss trend is based on California Fast Track data. For various reasons Fast Track data is not company-specific and is not reflective of Inter Insurance Exchanges experience. The regulation would preclude company actuaries from using other tools that may be more appropriate. The complement of credibility should be based on company-specific data.

Response: Fast Track data are readily available and robust. The use of Fast Track data enhances regulatory consistency. For many years, many insurers have relied on ISO calculated by-line "generic" trends, base on ISO data, for the complement of credibility.

With that said, in response to this and other similar comments, the revision proposes to do away with the generic trending, so as to enhance flexibility, among other things. A process must be in place to test company-specific, by-line trending. That is why the Commissioner determined a complement of credibility standard is needed. This process must provide a consistent and dependable test. The Commissioner recognizes that there exist other reasonable methods for determining the complement of credibility. In order to provide consistency and fairness and to keep the job of rate regulation manageable the Commissioner has determined the selected methodology as to the complement of credibility is reasonable and necessary, and complies with standard actuarial principles.

Commentor: Randall Farwell, on behalf of the Interinsurance Exchange of the Automobile Club; September 13, 2006; pages 2, 4.

Summary: Insurers should be allowed to supply rolling calendar year calculations for 4, 6, 8, 10 and 12 point trend lines based on company data.

Response: Insurers are to free select from 24 point, 12 point, 8 point, 6 point and 4 point fits. However, 12 quarters of rolling data is a widely accepted historical time frame to use in loss trending and that is the measure by which an insurer's trend calculations will be tested. In addition, years of experience gained in case-by-case determinations have led the Commissioner to determine that the use of 12 quarters of rolling data ensures actuarially sound results.

Commentor: Randall Farwell, on behalf of the Interinsurance Exchange of the Automobile Club; September 13, 2006; pages 2, 5.

Summary: This approach does not allow for trend factor selections to consider changing conditions.

Response: A proposed variance relating to loss and premium trend has been added to the variance section of the regulations, section 2644.7(f)(10). This variance was added in response to this and similar comments made during this rulemaking, the prior workshops and / or in relation to case-by-case determinations. This variance specifically addresses

changes in conditions relating to losses. Additionally, the regulation provides that the Commissioner may modify the result of the calculation from California Fast Track data to take into account factors not reflected in the historical data.

Commentor: Randall Farwell, on behalf of the Interinsurance Exchange of the Automobile Club; September 13, 2006; pages 2, 5.

Summary: Allowance should be made for the impact of one time process improvements, e.g., more accurate annual mileage data, on either premium or loss trends.

Response: The regulations provide for a variance for trend (section 2644.27(f)(10)) in five specific situations. The commissioner believes these five situations accommodate virtually all cases where some kind of accommodation is appropriate, including that raised by the commentor.

Commentor: Randall Farwell, on behalf of the Interinsurance Exchange of the Automobile Club; September 13, 2006; pages 2, 5.

Summary: The regulations should allow for the use of "two-step trend factors." This technique better reflects changing environmental or operational conditions.

Response: Variance section 2644.7(f)(10) may be applicable in relation to changing environmental or operational conditions. Otherwise, as explained above, the Commissioner has determined that one, consistent methodology is the most prudent and equitable approach regarding the testing of insurer trend calculations.

If by two-step process the comment is referring to first estimating what the ultimate claim costs will be over the recent past, and then performing further adjustment to reflect environmental or operations changes, to the extent environmental or operation changes had a significant impact on losses, the variance in section 2644.7(f)(10) would almost certainly apply, in which case the insurer may employ the two-step process and the Department would consider it.

Commentor: William K. Johanneson, on behalf of Farmers Insurance Group, September 13, 2006, pages 1, 3-4.

Summary: The requirements relating to the calculation of loss and premium trends are unnecessary and unduly restrictive. Insurers will be unable to account for changes in claim costs, claim frequencies, expenses, exposures, and premiums over the trending period.

Response: Section 2644.27(f)(10) allows a variance when, among other things, there is a significant change in the law, there are changes in the insurer's claims closing practices, or there are changes in coverage or other policy terms. This comment is therefore rejected.

Commentor: William K. Johanneson, on behalf of Farmers Insurance Group, September 13, 2006, pages 1, 4.

Summary: The regulation should allow for the use of the following, without requirement of a variance request: (a) company-specific incurred loss data in addition to paid, to address any changes in possible claims settlement practices; (b) a trend based on more or fewer years of data than the proscribed 12 quarters, to allow for changing conditions in legislative, regulatory or economic climate; and (c) a trend based on either rolling or quarterly non-rolling points.

Response: The variance provided in section 2644.7(f)(10) addresses the issues set forth in the comment. The Commissioner has determined that the best way to account for such circumstances is through the variance process. Under the variance process set forth in the proposed regulations, the insurer need only provide the information set forth in section 2644.27(b). The variance request will be determined in connection with review of the rate application. The process is not burdensome, yet complies with the purposes of Proposition 103 and the prior approval laws upheld in *CalFarm* and *20th Century.*

Commentor: William K. Johanneson, on behalf of Farmers Insurance Group, September 13, 2006, pages 1, 4.

Summary: Subsection (c) should be revised. The use of 6,000 total claims seems arbitrary. Instead, the regulation should remain silent on the topic of credibility standard, or to allow for one based on standard actuarial practices.

Response: The use of 6, 000 total claims counts applies only to homeowners and private passenger auto lines. This is considered an acceptable actuarial practice. Credibility for trend generally requires more claims. Ratemaking relies in great part on reviewing averages, all of which are mean value concepts. All of these values are random variables which contain sampling variances. In the case of trend, we are observing differences between two values, then and the future, the difference between two averages. The variance of the difference between two independent variables is the sum of the variances of the two variables. This means that if two averages are based on approximately the same volume of experience, twice as many claims are needed in each average to produce the same level of credibility in the difference between them. Therefore, the standard for full credibility for loss trend must employ twice the number of claims to meet the standard for full credibility (3,000 x 2 = 6,000).

Relying on experience in gained in many years of case-by-case determinations, the Commissioner has determined that in homeowners and private passenger auto lines for the purposes of trending, 6,000 total claims represents the minimum proper amount of data necessary in order to ensure accurate results.

Commentor: William K. Johanneson, on behalf of Farmers Insurance Group, September 13, 2006, pages 1, 4.

Summary: The requirement that the data be trended separately for homeowners is unnecessarily restrictive. The language should be revised to allow companies to trend by peril/coverage for homeowners.

Response: The regulations do not prevent insurers from trending homeowners losses by peril and coverage. Subsection (b) recognizes that where the trend factor within a given line significantly varies by subline, by policy limits, by region, or by coverage, separate trend factors shall be calculated in accordance with that evidence.

Commentor: Pamela Pressley, on behalf of the Foundation for Taxpayer and Consumer Rights (FTCR); September 13, 2006, page 5,
Allan I. Schwartz, on behalf of FTCR, September 13, 2006, page 6; oral statement of Allan Schwartz (FTCR), September 13, 2006, transcript pages 52-53.
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Summary: The proposed credibility standard of 6,000 claims is a much lower credibility standard than is commonly used for trend. The use of a lower credibility standard will result in more fluctuations and instability in the trend calculations, which will lead to more variability and uncertainty in the rates over time.

Response: Please see response to similar comment made by Mr. Johanneson, above.

Commentor: Pamela Pressley, on behalf of the Foundation for Taxpayer and Consumer Rights (FTCR); September 13, 2006, page 5,
Allan I. Schwartz, on behalf of FTCR, September 13, 2006, page 6; oral statement of Allan Schwartz (FTCR), September 13, 2006, transcript pages 52-53.

Summary: The regulation should be changed to indicate the Fast Track data for California should be used.

Response: This comment has been adopted. In response to this comment the most recent revision to the regulation requires California Fast Track data

Commentor: Pamela Pressley, on behalf of the Foundation for Taxpayer and Consumer Rights (FTCR); September 13, 2006, page 5,
Allan I. Schwartz, on behalf of FTCR, September 13, 2006, page 6; oral statement of Allan Schwartz (FTCR), September 13, 2006, transcript pages 52-53.

Summary: There is no credibility method relating to homeowners. The regulations should provide a complement of credibility, based on California Fast Track data, for all policy forms combined, excluding catastrophes data.

Response: The regulations provide a standard for full credibility for each form for homeowners policies. Relying on experience in gained in many years of case-by-case determinations and standard actuarial practice, the Commissioner has determined that in homeowners for the purposes of trending, 6000 total claims represents the appropriate

amount of data needed to ensure accurate results. For the same reason, the Commissioner disagrees that all policy forms should be combined.

Commentor: Pamela Pressley, on behalf of the Foundation for Taxpayer and Consumer Rights (FTCR); September 13, 2006, page 5,
Allan I. Schwartz, on behalf of FTCR, September 13, 2006, page 6; oral statement of Allan Schwartz (FTCR), September 13, 2006, transcript pages 52-53.

Summary: There was a comment made about whether the Department is using a pure premium method or a loss ratio method because of certain factors the Department has in the proposed regulation regarding on level factors and premium trend. As I understood the comment, it was that those are only applicable to a loss ratio method. I disagree with that. Those factors can be part of a pure premium method, and the on-level factors are used in calculating the ultimate pure premium for the complementary credibility, and so that would be used in a pure premium method.

Response: The Commissioner agrees with this comment.

Commentor: Pamela Pressley, on behalf of the Foundation for Taxpayer and Consumer Rights (FTCR); September 13, 2006, page 5,
Allan I. Schwartz, on behalf of FTCR, September 13, 2006, page 6; oral statement of Allan Schwartz (FTCR), September 13, 2006, transcript pages 52-53.

Summary: Premium trend is a misnomer. A more technically accurate term would be exposure trend because what you're really measuring is how much the exposures are changing over time due to things like inflation. So I would just say on those two factors, "simply putting in on-level factors and premium trend, to me I didn't find that confusing, just somehow indicate that each incident methodology that they're using"

Response: The Commissioner agrees that the regulation is not confusing.

Commentor Michael A. Walters, Towers Perrin, on behalf of the Association of California Insurance Companies; September 13, 2006; page 16

Summary: Twelve quarters of calendar year paid claim cost and frequency data may not be adequate. For longer tail lines, there is a likelihood that timing of payment variation distorts the results. Company specific data involves the risk of changing books of business within the trend measurement period, and may create further distortions between calendar payment and earned exposure.

Response: The October 5, 2006, changes to the regulation text address the concerns reflected in this comment. The regulation now allows reported claims for frequency. It also allows matching of paid losses to closed claims for severity.

Commentor Michael A. Walters, Towers Perrin, on behalf of the Association of California Insurance Companies; September 13, 2006; page 16

Summary: The trend period measurement should often be longer than the basic ratemaking experience period. The curve of best fit is not always the best measure; randomness is still a concern. Additionally, there are standards to apply even after taking a simple curve fit.

Response: Additional changes were made to this section in the October 5, 2006, version of these regulations. The language "as measured by the coefficient of determination" has been deleted. Additional language has been added to subsection (a). In response to comments made, the Commissioner has determined that the revised language appropriately addresses the concerns raised regarding this section. Additionally, the variance provided in section 2644.7(f)(10) is available in appropriate circumstances.

Commentor Shawna Ackerman, Pinnacle Actuarial Resources, Inc., on behalf of ACIC, PIFC, AIA; September 13, 2006; page 12;
Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 12

Summary: Subsection (a) serves no purpose because later sentences in subsection (a) dictate the data and period over which trend is to be calculated. It is unnecessary and confusing.

Response: In response to this and other similar comment the language in that section has been revised.

Commentor Shawna Ackerman, Pinnacle Actuarial Resources, Inc., on behalf of ACIC, PIFC, AIA; September 13, 2006; page 12;
Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 12 - 13

Summary: Subsection (c) specifies the complement of credibility as Fast Track. Competitor data may be more relevant and should be allowed. This section is particularly problematic for motorcycle because Fast Track does not include motorcycle.

Response: The proposed change as to motorcycle has been adopted. The proposed text has been amended to clarify that the appropriate data is California Fast Track data.

Fast Track data are readily available. The use of Fast Track data enhances regulatory consistency. Fast Track data does include competitor data. For many years, many insurers have relied on Fast Track data.

Commentor Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 8 - 9

Summary: The regulation provides that loss and premium trends be computed using the exponential function with the best fit and as modified by the Commissioner to take into account factors not reflected in the historical data. Loss trends are to be developed using company-specific paid loss, closed-claim and earned exposure data. Premium trends are to be developed using company-specific premiums per exposure data. The insurer's most recent 12 quarters of rolling calendar year data are to be used. The following problems remain with the regulation:

The requirement that paid data be used for all lines, regardless of circumstances, is overly restrictive and for long tailed lines is likely to produce inaccurate trends.

Use of three years of data only will increase the volatility of indications for auto and homeowners coverage.

At different points in time, paid data may produce higher or lower indications than incurred data. Use of paid data only means that the data used will not reflect current trends. When trends are changing quickly, the use of paid data only will produce inaccurate indications.

Mandatory use of rolling 12 month data will unnecessarily introduce autocorrelation into the time series used for trend so that simple linear or exponential trends on the autocorrelated data will yield inaccurate results without an autocorrelation correction. The regulation should be revised to remove the rolling four quarters requirement, the restriction on only three years of data, and the single use of an exponential fit to the data, replacing the latter with an actuarially accepted trending methodology that may include a seasonality adjustment when appropriate.

It is unclear how the Commissioner will be able to modify a company-specific trend for factors not reflected in the historical data.

The regulation sets forth a standard for credibility, but it is not clear how claims are to be counted in the trend analysis. It could include the latest year, average annual claim count, or all claims used in the trend analysis. The regulation is silent on whether the claim counts are on a per occurrence or per person basis. The same comments apply to the complement of credibility.

For other lines, the regulations should explicitly state that the credibility standard should be determined using an actuarially reasonable method.

Response: In response to this and similar comments the regulations were amended. The proposed regulations now provide that frequency trend shall be calculated as reported or closed claims divided by exposures. Severity trend shall be calculated on paid losses divided by closed claims or total paid losses, including partial payments in previous calendar years, on closed claims divided by closed claims.

To the extent this comment is referring to medical malpractice pursuant to section 2644.4(d), sections 2644.5 through 2644.7 no longer apply to medical malpractice. Additionally, subsection (b) provides that where the trend factor within a given line varies in specified ways, separate trend factors shall be calculated in accordance with that evidence.

The Commissioner has determined that 12 quarters of rolling data is the proper amount of data needed to ensure accurate results, and the Commissioner incorporates his responses to similar comments made elsewhere in this rulemaking file.

The variance set forth in section 2644.7(f)(10) was designed to address issues such as those raised by the commentor. Section 2644.7(f)(10) would apply where the trend formula in section 2644.7 does not produce an actuarially sound result because there is a significant increase or decrease in the amount of business written or significant changes in the mix of business; there is a significant change in the law affecting the frequency or severity of claims; it can be shown that trends calculated over at least a 10-year period are more reliable prospectively; there are changes in the insurer's claims closing practices that significantly affect the data; or there are changes in coverage or other policy terms that significantly affect the data. This variance was designed to address those situations where trends tend to "change quickly."

The comment states that use of the proposed procedures for loss trend will result in "autocorrelation" which will in turn yield inaccurate results unless those results are corrected. While the Commissioner has determined that 12 quarters of rolling data is the minimum amount of data needed to ensure credibility, in response to this and similar comments, Section § 2644.7(f)(10) has been added to the regulations. This variance is designed to address concerns relating to the twelve quarters of rolling data requirement. Where an insurer can show that trends calculated over at least a 10-year period are more reliable prospectively, the insurer could avail itself of this variance.

The rolling four quarters method is the most straightforward way of dealing with the problems associated with seasonality in data. The Commissioner finds that the benefits of dealing with seasonality distortions outweigh the potential risks of autocorrelation.

The Commissioner has determined that the methodology set forth is an actuarially accepted trending methodology and the comment provides no evidence, other than speculation, to refute that determination. For the same reason, the Commissioner is not prepared to introduce a seasonality adjustment into the regulations at the present time.

The comment states that the regulations are unclear as to how the Commissioner will take into account factors not reflected in the historical data. However, the regulation provides that such a modification shall be made through the process set forth in section 2646.3. Therefore, the Commissioner believes this portion of the regulation is clear, and rejects that portion of the comment.

As to how claims are counted, the Commissioner believes that the regulation is clear. Likewise, the Commissioner believes that it is not necessary to state that for other lines, the credibility standard should be determined using an actuarially reasonable method, since such a conclusion is obvious.

Commentor James Hurley; on behalf of California Association of Professional Liability Insurers (CAPLI), September 12, 2006; page 4.

Summary: The premium trend calculation should not apply to medical malpractice insurance; since medical malpractice is rated on a per physician year basis there is no need to account for inflation.

Response: In response to this and other similar comments, the regulations have been amended. Pursuant to section 2644.4(d), sections 2644.5 through 2644.7 do not apply to medical malpractice.

Commentor James Hurley; on behalf of California Association of Professional Liability Insurers (CAPLI), September 12, 2006; page 4.

Summary: The specified use of paid losses and closed claims counts as those relate to the 12 quarters of rolling data will produce inappropriate and unsound results. This is due, in part, to the relatively long delay from occurrence to report to closure of a medical malpractice claim and because significant money is paid over the life of the claim, in investigating, researching and resolving the claim.

Response: In response to this and other similar comments, the regulations have been amended. Pursuant to section 2644.4(d), sections 2644.5 through 2644.7 do not apply to medical malpractice.

Commentor James Hurley; on behalf of California Association of Professional Liability Insurers (CAPLI), September 12, 2006; page 4.

Summary: Due to the long delay between occurrence to report to closure of a claim medical malpractice insurers should be allowed to consider data on a report year basis.

Response: In response to this and other similar comments, the regulations have been amended. Pursuant to section 2644.4(d), sections 2644.5 through 2644.7 do not apply to medical malpractice.

Commentor James Hurley; on behalf of California Association of Professional Liability Insurers (CAPLI), September 12, 2006; page 4.

Summary: The use of total loss payouts will distort the results for medical malpractice insurance. Trends should be examined at specified limits. Layering loss or adjusting for the presence or absence of large claims should be allowed under the proposed regulations.

Response: In response to this and other similar comments, the regulations have been amended. Pursuant to section 2644.4(d), sections 2644.5 through 2644.7 do not apply to medical malpractice.

Commentor James Hurley; on behalf of California Association of Professional Liability Insurers (CAPLI), September 12, 2006; page 5.

Summary: The regulations are unclear as to whether the trend analysis is to be performed on a pure premium basis or separately reviewing frequency and average claim cost (severity). There is a material mismatch between paid dollars and closed claims, between paid dollars and earned exposures and between closed claims and earned exposures which will result in inappropriate trending.

Response: In response to this and similar comments the regulations were amended. The regulations now state specifically that frequency trend shall be calculated as reported or closed claims divided by exposures. Severity trend shall be calculated on paid losses divided by closed claims or total paid losses, including partial payments in previous calendar years, on closed claims divided by closed claims.

To the extent this comment is specific to medical malpractice insurance. in response to this and other similar comments, the regulations have been amended. Pursuant to section 2644.4(d), sections 2644.5 through 2644.7 do not apply to medical malpractice.

Commentor James Hurley; on behalf of California Association of Professional Liability Insurers (CAPLI), September 12, 2006; page 5.

Summary: The use of twelve quarters of rolling calendar year data is inappropriate for medical malpractice. As stated above the nature of medical malpractice insurance requires a longer time period for trending.

Response: In response to this and other similar comments, the regulations have been amended. Pursuant to section 2644.4(d), sections 2644.5 through 2644.7 do not apply to medical malpractice.

Commentor James Hurley; on behalf of California Association of Professional Liability Insurers (CAPLI), September 12, 2006; page 5.

Summary: The proposed regulation specifies that trend factors shall be based on the best fit measured by the CD. For all of the reasons stated this requirement will cause incorrect results. An example is included in Table A

Response: In response to this and other similar comments, the regulations have been amended. Pursuant to section 2644.4(d), sections 2644.5 through 2644.7 do not apply to medical malpractice.

Commentor James Hurley; on behalf of California Association of Professional Liability Insurers (CAPLI), September 12, 2006; page 6.

Summary: Medical malpractice insurers should be allowed to base the trend on the exponential fit of the latest twelve quarters of rolling calendar year data without regard to the CD. An illustration is included in Table B.

Response: In response to this and other similar comments, the regulations have been amended. Pursuant to section 2644.4(d), sections 2644.5 through 2644.7 do not apply to medical malpractice.

Commentor James Hurley; on behalf of California Association of Professional Liability Insurers (CAPLI), September 12, 2006; page 6.

Summary: Not addressed is that there are a number of components critical to medical malpractice that should be analyzed separately.

Response: Please see response above. Pursuant to section 2644.4(d), sections 2644.5 through 2644.7 do not apply to medical malpractice.

Commentor James Hurley; on behalf of California Association of Professional Liability Insurers (CAPLI), September 12, 2006; page 6.

Summary: A four-page study is attached that notes the importance of including information on open claims in evaluating medical malpractice loss experience in ratemaking. It discusses some of the factors that should be considered when working with closed-claim databases. However it is not specifically directed at these regulations.

Response: To the extent the study is applicable to these regulations, the Commissioner notes that the regulations have been amended. Pursuant to section 2644.4(d), sections 2644.5 through 2644.7 do not apply to medical malpractice.

Commentor Jeff Donaldson, Devin O'Brien, Hillary Rowen; Supplemental Comments by The Doctors Company, September 13, 2006; page 2.

Summary: When applied to long-tail lines, like claims-made policies, under the proposed methodology losses and claims are not matched with exposures. For claims-made policies, medical malpractice policies, the time period for measuring exposures is report-year. This approach results in a matching of losses with the exposures that generated those losses.

Response: In response to this and other similar comments, the regulations have been amended. Pursuant to section 2644.4(d), sections 2644.5 through 2644.7 do not apply to medical malpractice.

Commentor Jeff Donaldson, Devin O'Brien, Hillary Rowen; Supplemental Comments by The Doctors Company, September 13, 2006; page 2.

Summary: In medical malpractice line since less than 10% of report year losses are paid within that same year, and about 30% of reported claims will be closed by the end of the report year, the vast majority of paid losses and closed claim counts for a calendar year are related to claims reported in prior years. Thus there is a significant mismatch between the calendar year loss/claim data and the report year earned exposures.

Response: In response to this and other similar comments, the regulations have been amended. Pursuant to section 2644.4(d), sections 2644.5 through 2644.7 do not apply to medical malpractice.

Commentor Jeff Donaldson, Devin O'Brien, Hillary Rowen; Supplemental Comments by The Doctors Company, September 13, 2006; page 2.

Summary: Exposure information on rolling calendar years is not available. Report-year data is readily available. Calendar year data do not have earned exposure algorithms to measure a year's worth of exposures ending on a date other than year-end. The generation of the year-ending quarterly data regulation is problematic. For claims-made policies, projected losses should be calculated on a report-year basis.

Response: The comment applies to medical malpractice coverage. In response to this and other similar comments, the regulations have been amended. Pursuant to section 2644.4(d), sections 2644.5 through 2644.7 do not apply to medical malpractice.

Commentor Jeff Donaldson, Devin O'Brien, Hillary Rowen; Supplemental Comments by The Doctors Company, September 13, 2006; page 2 – 3.

Summary: Closed claim data is not responsive to recent loss activity. Medical malpractice claims average about three years between the date of loss reporting and resolution. The most recent claims data used for trend selection is about four and a half years prior to the prospective dates of resolution for the projected losses. This time lag compromises responsiveness to current loss trends. Use of report year data for loss trending would reduce this lag time from 4.5 years down to 1.5 years.

Response: In response to this and other similar comments, the regulations have been amended. Pursuant to section 2644.4(d), sections 2644.5 through 2644.7 do not apply to medical malpractice.

Commentor Jeff Donaldson, Devin O'Brien, Hillary Rowen; Supplemental Comments by The Doctors Company, September 13, 2006; page 3 – 4.

Summary: The specified experience period is too short for the volatile and long-tailed medical malpractice line of business and will result in unstable rates. Section §2644.7, requires the use of the "… most recent 12 quarters of rolling calendar year data ...." This

equates to 3.75 years worth of calendar year data. For a line of business such as medical malpractice, this short time period produces very volatile trend indications.

Response: In response to this and other similar comments, the regulations have been amended. Pursuant to section 2644.4(d), sections 2644.5 through 2644.7 do not apply to medical malpractice.

Commentor Jeff Donaldson, Devin O'Brien, Hillary Rowen; Supplemental Comments by The Doctors Company, September 13, 2006; page 3 – 4.

Summary: The comment includes an exhibit containing detailed calculations. (Exhibit 1). The exhibit purports to show that the specified exposure period in section 2644.7 – the most recent 12 quarters of rolling calendar year data – results in unreliable trend projections because the required time period is too short. These large changes in trend projections create significant pricing impacts. This price volatility is detrimental to insurers, and even more objectionable to the insureds.

Response: In response to this and other similar comments, the regulations have been amended. Pursuant to section 2644.4(d), sections 2644.5 through 2644.7 do not apply to medical malpractice.

Commentor Jeff Donaldson, Devin O'Brien, Hillary Rowen; Supplemental Comments by The Doctors Company, September 13, 2006; page 3 – 4.

Summary: Requiring a fixed time length for the trend calculations is not appropriate. Rather we believe that report year trends should be analyzed in accordance with actuarial standards of practice. Classifying medical malpractice as a specialty line in section 2642.7 would resolve the problems arising from applying the "one-size-fits-most" trend methodology specified in section 2644.4 to medical malpractice.

Response: As stated above, in response to these and similar comments, the regulations have been amended. Pursuant to section 2644.4(d), sections 2644.5 through 2644.7 do not apply to medical malpractice.

Commentor: Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 12 – 13

Summary: Motorcycle should be added as a separate line of insurance. The efficiency standard applied to motorcycle must be fair and appropriate. With respect to the efficiency standard, motorcycle premiums are less than a third of auto premiums and the policy acquisition costs are generally higher. The fixed expenses as a percentage of premium are higher. Unless motorcycle is treated as a separate line, insurers will be prevented from recovering legitimate and necessary expenses associated with acquiring and servicing this line of business and the inability to recover these expenses will have little relationship to the efficiency of an insurer's operation.

Response: As revised, section 2644.7 of the regulations distinguishes motorcycle. As to the efficiency standard comments, motorcycle is not considered a separate line in the existing regulations, and that approach has been continued in the proposed regulations. Therefore, these are not comments related to changed portions of the regulations and a detailed response is not required. However, in response to comments such as these, in the October 5, 2006, version of the proposed regulations, section 2644.27(f)(3)(C) has been added to recognize a variance for a significantly smaller or larger than average policy size, which would include motorcycle.

Section 2644.8 Projected Defense and Cost Containment Expenses

In 1998 the National Association of Insurance Commissioners revised the definitions of Allocated Loss Adjustment Expense (ALAE) and Unallocated Loss Adjustment Expense (ULAE) in order to improve the consistency of reporting among all insurers. The term now used by the NAIC and in the revisions is "Defense and Cost Containment Expenses" otherwise known as DCCE. The Commissioner wishes to be consistent with the other states in this regard and is therefore proposing revisions to the terminology in the regulations pursuant to the NAIC model. The treatment of DCCE is consistent with the methodology employed in the current regulations.

As stated above, what the proposed revision refers to as Defense and Cost Containment Expenses were formerly referred to as Allocated Loss Adjustment Expenses, or "ALAE." These are the costs associated with the defending of specific claims. The term "allocated" was used to denote that these costs were those associated with settling and defending specific claims to which those costs would be allocated as opposed to general costs associated with, for example, running an in-house claims operation. The term defense and cost containment expenses should be given the same meaning as ALAE. Unallocated loss adjustment expenses not captured under the definition of DCCE are now captured in the efficiency standard under "adjusting and other expenses."

The Commissioner recognizes historical costs associated with defense and cost containment are integral to the ratemaking process. The California Supreme Court also recognized the use of this factor in the ratemaking formula. As with other historical data, DCCE must also be adjusted and trended in order effectively project these costs into the future. The proposed revisions require historical DCCE data be developed and trended in pursuant to sectopm 2644.5, (catastrophe adjustment) 2644.6 (loss development) and 2644.7 (lost trend and premium trend.) These factors are discussed in detail above.

Commentor Mary B. Gaillard, on behalf of AIG, September 12, 2006, page 3.

Summary: The use of DCCE as apposed to ALAE eliminates the recognition of company-specific claims handling fees (adjuster expenses). Use of DCCE as opposed to ALAE ignores company specific claims handling practices and philosophies.

Response: In 1998 the National Association of Insurance Commissioners revised the definitions of Allocated Loss Adjustment Expense (ALAE) and Unallocated Loss

Adjustment Expense (ULAE) in order to improve the consistency of reporting among all insurers. The term now used by the NAIC and in the revisions is "Defense and Cost Containment Expenses" otherwise known as DCCE. For the most part, using DCCE as opposed to ALAE is merely a change in terminology. Most of the same costs are recognized in DCCE as they were in ALAE. DCCE are company-specific and claim-specific loss adjustment expenses. These are the expenses that related to the defense, litigation, or cost containment of a specific claim. These costs include surveillance, appraisers, private investigators, and fraud investigators, and all expenses associated with the defense of a specific claim.

Just as it is in the current regulation as relates to ALAE, the proposed regulation allows the insurer to recover its DCCE. Because the terminology ALAE is no longer used by the NAIC and is no longer recognized for various reporting purposes, it is no longer appropriate to refer to ALAE in these regulations. As such, the comment is rejected.

Commentor Mary B. Gaillard, on behalf of AIG, September 12, 2006, page 3.

Summary: The option to develop defense and cost containment or to use a ratio to losses should apply to all lines of business, and not be limited only to liability lines.

Response: The option to develop defense and cost containment or to use a ratio to losses is limited to liability coverages only because liability lines, those most often associated with third party claims, have significantly higher defense costs. This approach is being proposed because the costs associated with liability are such that it may be more appropriate to recognize those losses differently.

As other lines and coverages do not present the same potential for impact on loss costs as those associated with liability those losses are more appropriately recognized as DCCE. For these reasons the comment is rejected.

Commentor: William K. Johanneson, on behalf of Farmers Insurance Group, September 13, 2006, pages 1, 4.

Summary: The option to develop defense and cost containment or to use a ratio to losses should apply to all lines of business, and not be limited only to liability lines.

Response: Please see response to similar comment above.

Commentor: William K. Johanneson, on behalf of Farmers Insurance Group, September 13, 2006, pages 1, 4

Summary: The requirement that defense and cost containment expenses data must be adjusted for catastrophes is unduly burdensome for companies that may not have catastrophe detail in their expense data.

Response: The current regulation requires that ALAE be developed and trended. The proposed DCCE revision adds to those required adjustments a required catastrophe adjustment. This change was made in response to comments submitted during the workshop process. The impact of catastrophe losses tends to manifest more obviously in relation to property losses. And, DCCE is not regarded as a major factor in property losses (as DCCE tends to be associated more with bodily injury and liability coverages). As such, at the time of the drafting of the current regulations it was decided that there would be no requirement of a catastrophe adjustment in relation to ALAE. However, experience gained in 15 years of case-by-case determinations, the growing focus on catastrophes and due to comments made, the Commissioner has determined that there are enough situations where a catastrophe adjustment to DCCE is appropriate that it should be a required adjustment.

It should also be noted that making the catastrophe adjustment a requirement for DCCE makes the treatment of DCCE consistent with the procedure used for projected losses in section 2644.4. The Commissioner believes this will yield more accurate results. To the extent DCCE is impacted by catastrophe losses, that impact should be reflected in the rate in the most reliable manner.

Commentor: William K. Johanneson, on behalf of Farmers Insurance Group, September 13, 2006, pages 1, 4

Summary: The variances allowed for loss development and loss trend should apply equally to projected defense and cost containment expenses.

Response: Projected DCCE is developed and trended as set forth in sections 2644.6, and 2644.7. The variances set forth in section 2644.27(f)(9) and (10) specifically refer to sections 2644.6 and 2644.7 and do not distinguish between loss and DCCE.

Commentor: Allan I. Schwartz, on behalf of FTCR, September 13, 2006, pages 6-7.

Summary: Allowing insurers a choice of two different procedures opens up the strong likelihood of insurers selecting the method that tends to give the highest result in each rate filing, which will lead to an upward bias in the rates. There are three possible solutions: (1) require that either one or the other of the two methods given in the proposed regulation be used; (2) require that an average of some sort be used; (3) clarify that the defense and cost containment method used by the insurer in the rate filing is not presumed to be reasonable, that either the CDI or an intervenor may propose a different method to use, and that the burden of proof still falls on the insurer to justify the method it selected for use in the rate filing.

Response: Proposition 103 and regulation Section 2646.5 provides that the insurer has burden of proof. The regulation has been further amended in response to comments and now provides that the insurer shall demonstrate that its selection is the most actuarially reasonable. Under applicable statutory provisions, CDI or an intervenor may propose a different method. Where choices are offered, those choices are subject to

scrutiny as to whether they are actuarially reasonable and meet the requirements of the regulation. The Commissioner sees no utility in requiring an averaging of the two methods. The Commissioner has determined that the options as set forth in § 2644.8 are consistent with the law, actuarially sound, and necessary.

Commentor: Allan I. Schwartz, on behalf of FTCR, September 13, 2006, pages 6-7.

Summary: The regulation does not address the issue of how to calculate defense and cost containment expenses for coverages other than liability, and it should be modified to indicate how defense and cost containment expenses should be calculated for these non-liability coverages.

Response: DCCE is considerably less significant for non-liability than for liability coverages. Therefore, the Commissioner has determined that there is no necessity for specifying a methodology for non-liability coverages.

Commentor: Randall Farwell, on behalf of the Interinsurance Exchange of the Automobile Club; September 13, 2006; page 5.

Summary: This section contains limitations to how a carrier may develop the ratio of defense and cost containment expenses to losses. While not exactly the same as section 2644.6, the result is a similar limitation in actuarial methodology.

Response: The existing regulations provide that ALAE shall be developed and trended as described in sections 2644.6 and 2644.7. The change proposed to this section also recognizes adjustments for catastrophes. Changes to subsection (b) allow insurers further alternatives for liability coverages. The Commissioner had determined that the proposed revisions do not impose unreasonable restrictions or limitations on the manner in which a carrier may develop the ratio.

Commentor: Milo Pearson and Christian Rataj, on behalf of the Pacific Association of Domestic Insurance Companies (PADIC) /National Association of Mutual Insurance Companies (NAMIC); September 12, 2006; page 3.

Summary: CDI should define and enumerate what costs and expenses are covered under "defense and cost containment" (i.e., does it include first- party and third-party mediation and/or arbitration filing fees, related attorney's fees, arbitration or mediation expenses, document-preparation costs and witness fees; costs and expenses associated with Special Investigative Unit (SIU) activites; insurance-fraud education, prevention, investigation, and prosecution; inter-company property damage arbitration costs; claim-investigation costs and retention of experts to assist in liability assessments and damaged calculations; and subrogation costs and expenses?)

Response: The term has the same meaning as it does for NAIC and other state reporting purposes.

Commentor Shawna Ackerman, Pinnacle Actuarial Resources, Inc., on behalf of ACIC, PIFC, AIA; September 13, 2006; page 12 – 13;
Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 13

Summary: Changing the terminology from ALAE to DCCE removes the ability of an insurer to include individual company data on claim expenses that can be assigned to specific claims. This takes the individual company claims settling experience data out of the ratemaking process and is too restrictive. The fact that DCCE is used in Annual Statements does not make it appropriate to reflect the individual company expense experience. This provision is arbitrary, unsupported, lacks clarity, authority, consistency, and necessity.

Response: As set forth elsewhere in this rulemaking file, the change in terminology from ALAE to DCCE simply reflects the current National Association of Insurance Commissioners ("NAIC") terminology, correlates with use of data from the Annual Financial Statements, and is designed to ensure consistency.

Commentor Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 9 - 10

Summary: The same criticisms of loss development and loss trending apply to any separate DCCE trending. Alternatively, for liability coverages, the insurer can develop and trend combined loss and DCCE data or determine ultimate DCCE using the ratio of DCCE to losses. This flexibility is important, as DCCE data alone may not be stable enough for separate development and trending.

Response: The comment supports the language in section 2644.8(b) which provides that, for liability coverages, defense and cost containment expenses may be added to losses for loss development and trend or may be developed using ratios of defense and cost containment expenses to losses.

Section 2644.9 Projected Fixed Expenses

Commentor: Pamela Pressley, on behalf of the Foundation for Taxpayer and Consumer Rights (FTCR); September 13, 2006, page 4,
Allan I. Schwartz, on behalf of FTCR, September 13, 2006, pages 7-8.

Summary: CDI should not eliminate the use of an individual company's fixed and variable expenses in the rate calculation and requiring the use of the efficiency standard in all instances. To use the efficiency standard when a company's own expenses may be lower may result in windfall profits and excessive rates.

Response: The rulemaking file for the existing regulations indicated that the insurer is allowed to impute expenses at the efficiency standard. If the actual expense levels of the company are lower, the difference inures to the benefit of the company. Over time, it

was noted that the regulation language was not as clear on this point as it could have been. The changes relevant to the efficiency standard simply reflect the original intent.

Commentor: Pamela Pressley, on behalf of the Foundation for Taxpayer and Consumer Rights (FTCR); September 13, 2006, page 4;
Allan I. Schwartz, on behalf of FTCR, September 13, 2006, pages 2, 7-8

Summary: The efficiency standard unduly "rewards" insurers where the insurer's expenses are lower than that indicated by application of the efficiency standard. Where this occurs an average of the insurer's own expense experience and the efficiency standard would be a more appropriate measure.

Response: Please see response immediately above.

Section 2644.10 Excluded Expenses

Commentor: Foundation for Taxpayer and Consumer Rights; September 13, 2006; Allan I. Schwartz, on behalf of FTCR, September 13, 2006, page 8.

Summary: The definition of compensation is too narrow. The following definition should be used instead: "Executive compensation means the total remuneration accruing during the year, including both cash and non-cash items that have economic value to the executive. This includes, but is not limited to, salary, bonus, employee benefits, retirement benefits, stocks, bonds and options."

Response: The language in the existing regulations, moved to a different section in the proposed regulations, defines "compensation" as the "total cash paid, including salary and bonus." This language has worked well since it was first adopted and is not proposed for change. The Commissioner rejects the comment.

Commentor Richard J. Roth, Jr., Bickerstaff, Whatley, Ryan & Burkhalter, Inc.; September 11, 2006; page 2.

Summary: The executive compensation requirement for the five highest paid officers is nonsensical. Has the Department ever excluded any costs under this section? Information provided to the Department relates to the base salary paid by the specific company, but the individual is often an officer of many companies and often compensated by the holding company or another entity. Bonuses and other remuneration is often awarded after the filing has been made. This section doesn't advance the credibility of the Department.

Response: This section carries forth to the prior approval of insurance rates the executive compensation provisions included in the regulations applicable to insurance rate rollbacks and upheld by the Supreme Court in the *20th Century* case. Compensation is defined in the regulation as the total cash paid, including an executive's bonus. Because rate applications are filed on a company-by-company basis, the costs and

expenses of a company are reviewed on that basis. The fact that an individual may receive a bonus or raise after a rate application is filed, or may also receive compensation from another entity, should not prevent the Department from regulating this expense to the extent it is able to do so. A raise awarded to an executive after the filing of a rate application should be reflected in the next application.

Commentor Richard J. Roth, Jr., Bickerstaff, Whatley, Ryan & Burkhalter, Inc.; September 11, 2006; page 3.

Summary: It is not clear whether the base for "log" is 10 or e. Base 10 is rarely used. It is unclear where the formulas came from. What is the justification that they are reasonable.

Response: Natural logarithms, using e, are typically denoted "ln". Base 10 logarithms are typically denoted "log". The regulations follow this convention and thus are clear. The formula was first proposed, explained, and justified in connection with the rollback regulations, and upheld by the Supreme Court in the *20th Century* case.

Commentor Shawna Ackerman, Pinnacle Actuarial Resources, Inc., on behalf of ACIC, PIFC, AIA; September 13, 2006; page 13;
Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 14

Summary: Allowable executive compensation is calculated based on the rollback provisions of the regulations, which were developed almost 15 years ago. The Department has not undertaken further review to determine if the formula and parameters remain valid. This approach lacks authority and consistency and is based on outdated information.

Response: The compensation is based on a formula which uses current earned premium. Therefore, the Department has determined that it remains a valid number. The Department also notes that it has been applying these figures, without significant objection, in its review of prior approval applications, as authorized by the *Walker* decision.

Commentor Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 10.

Summary: The executive compensation portion of the formula is the same as that contained in the rollback regulations and there is no indication as to whether the Department has analyzed any data to determine whether the formula should be updated.

Response: Please see response to similar comment immediately above.

Section 2644.11 Expense Trend

The Department received no comments directed at this section, which is proposed for deletion.

Section 2644.12 Efficiency Standard

In *20th Century*, the Supreme Court upheld the use of the efficiency standard in the ratemaking formula. The court explained: "'Fixed expenses' are subject to an "efficiency standard"--a test of reasonableness--for each covered line of insurance, as established from time to time by the Insurance Commissioner in a generic determination. (*Cal. Code Regs., tit. 10, ß 2644.12*.) 587, 828

The proposed revision eliminates the "generic" approach and instead requires an annual update and provides a mechanism for the performing the calculation. Annual updates will assure the efficiency standard is as accurate as possible.

Proposition 103 implemented a system of rate regulation in California. Under Proposition 103, as modified by *Calfarm Insurance Company v. Deukmejian* (1989) 48 Cal.3d 805, insurers are entitled to the opportunity to earn a fair and reasonable rate of return. Court decisions interpreting the "fair rate of return" standard make it clear that the opportunity to achieve a fair return must be provided only to those who conduct their operations in a reasonably efficient manner. *Greenleaf Finance Company v. Small Loans Reg. Bd.* (1979) 385 N.E. 2d 1364. Thus, insurers may only pass on reasonable expenses to insurance consumers. The efficiency standard complies with this requirement.

Because insurance tends to be a cost-plus business, insurers have little incentive to avoid expenses that they can pass through to consumers. It is impossible for a regulatory agency to regulate price if one allows insurers complete freedom to spend money arbitrarily and excessively. Proposition 103 requires effective regulation of price. There is no constitutional right to protection of inefficiency.

The *Calfarm* and *20th Century* cases both stand for the proposition that the Commissioner has wide discretion to adopt rules and regulations as necessary to promote the public welfare.

There is no requirement anywhere in the law that all costs associated with the insurance enterprise be recognized in the ratemaking formula. Only the *reasonable* cost of providing insurance need be taken into account. As the California Supreme Court stated in *20th Century,* it is not objectionable that the ratemaking formula's efficiency standards operate to define the reasonable cost of providing insurance after subjecting the insurer's "expenses ... to downward normative pressure." (*Massachusetts Auto. Rating & Accident Prevention Bureau v. Commissioner of Ins. (1980) 381 Mass. 592, 602* [411 N.Ed.2d 762, 768].) . . . "[I]t surely cannot be reasonable for an investor to assume that each and every expenditure ... will be allowed by regulatory authorities." (*Jersey Cent. Power & Light Company v. F.E.R.C., 810 F.2d at p. 1193* (conc. opn. of Starr, J.).)

Commentor: Milo Pearson and Christian Rataj, on behalf of the Pacific Association of Domestic Insurance Companies (PADIC) /National Association of Mutual Insurance Companies (NAMIC); September 12, 2006; page 3,

David Appel, on behalf of Pacific Association of Domestic Insurance Companies/National Association of Mutual Insurance Companies; September 12, 2006; pages 8-10.

Note: While these comments appear under the heading: Sections 2644.2 and 2644.3, Maximum and Minimum Permitted Earned Premiums, they are responded to in this section as they focus almost exclusively on the efficiency standard.

Summary: We oppose an "efficiency standard" in lieu of fixed and variable expense because there is no mechanism in place to ensure that the "efficiency standard" set by CDI is not arbitrary and inconsistent with the actual business realities of many insurers.

Response: Use of an efficiency standard is commonly-recognized in rate and price regulation and the Commissioner's efficiency standard was specifically upheld by the Supreme Court in *20th Century*. The method for calculating the efficiency standard is set forth in the regulations. The Commissioner has determined that the methodology is not arbitrary and that it does recognize business realities. For example, it specifically recognizes that different expenses are associated with different distribution systems and lines of business. This comment is a general objection to any efficiency standard and is therefore rejected.

Commentor: Milo Pearson and Christian Rataj, on behalf of the Pacific Association of Domestic Insurance Companies (PADIC) /National Association of Mutual Insurance Companies (NAMIC); September 12, 2006; page 3,

David Appel, on behalf of Pacific Association of Domestic Insurance Companies/National Association of Mutual Insurance Companies; September 12, 2006; pages 8-10.

Summary: The "efficiency standard" could hurt small insurance carriers, domestic carriers, and regional carriers that do not benefit from the scale of economy that larger national carriers can use to allocate and distribute expenses.

Response: This comment urges abandonment of the efficiency standard on the ground that small insurers cannot achieve the scale efficiencies of large companies and are therefore the victims of discrimination in the application of the standard. However, the comment fails to recognize that the revisions to section 2644.27(f)(5) for predominately mono-line and California companies addresses virtually all small insurers.

Moreover, there has been no compelling demonstration of pronounced scale efficiencies in the insurance industry. While there are some large companies that are efficient, some large companies fail to meet the efficiency standard and numerous small companies have been shown to be highly efficient. Some small or regional insurers are very efficient for that exact reason.

In *20th Century,* in approving the use of the current regulations, the Supreme Court held: "It is not objectionable that the ratemaking formula's efficiency standards operate to define the reasonable cost of providing insurance." The court acknowledged the efficacy of the efficiency standard. For this reason and for the reasons stated above, the Commissioner rejects the suggestion that the efficiency standard be abandoned.

Commentor: Milo Pearson and Christian Rataj, on behalf of the Pacific Association of Domestic Insurance Companies (PADIC) /National Association of Mutual Insurance Companies (NAMIC); September 12, 2006; page 3,

David Appel, on behalf of Pacific Association of Domestic Insurance Companies/National Association of Mutual Insurance Companies; September 12, 2006; pages 8-10.

Summary: The efficiency standard could have a chilling effect upon corporate research and development of new insurance products and the marketing of products to underserved communities in the state.

Response: This comment is complete speculation and no basis is provided for the comment. It is therefore impossible to respond, except to note that the Commissioner has determined that an efficiency standard is necessary and appropriate for the reasons stated elsewhere in this rulemaking file. An efficiency standard has been in effect since these regulations were first promulgated approximately 15 years ago, with no demonstrated negative effect on development of new insurance products and the marketing of products to underserved communities. Variances are available in section 2644.27(f)(3)(B) and (4) to address the concerns expressed.

Commentor: Milo Pearson and Christian Rataj, on behalf of the Pacific Association of Domestic Insurance Companies (PADIC) /National Association of Mutual Insurance Companies (NAMIC); September 12, 2006; page 3,

David Appel, on behalf of Pacific Association of Domestic Insurance Companies/National Association of Mutual Insurance Companies; September 12, 2006; pages 8-10.

Summary: By requiring carriers to adjust their established underwriting, claims, and sales practices to conform to an "efficiency standard," certain carriers may have to reduce the quality and quantity of business services provided to consumers. This could result in underwriting and claim-settlement delays, which would be to the detriment of consumers.

Response: Please see response to comment immediately above, which is hereby incorporated herein by this reference.

Commentor: Milo Pearson and Christian Rataj, on behalf of the Pacific Association of Domestic Insurance Companies (PADIC) /National Association of Mutual Insurance Companies (NAMIC); September 12, 2006; page 3,

David Appel, on behalf of Pacific Association of Domestic Insurance Companies/National Association of Mutual Insurance Companies; September 12, 2006; pages 8-10.

Summary: Since "defense and cost containment" have replaced "allocated loss adjustment expenses (ALAE)" in the Earned Premium, we request that CDI clarify and define what specific costs and expenses are covered under the definition of "defense and cost containment."

Response: Please see response to similar comments elsewhere in this rulemaking file. The term has the same meaning as ascribed to it by the NAIC.

Commentor Mary B. Gaillard, on behalf of AIG, September 12, 2006, page 3; oral statement of Mary Gaillard (AIG), September 13, 2006, transcript pages 37-41.

Summary: CDI should not use industry averages rather than company-specific information.

Adjuster expenses should not be included within the efficiency standard and should continue to be a company specific calculation. In addition, the use of a simple three-year average of the industry expense provisions as the efficiency standard may be too limiting.

The efficiency standard should be set at the three-year average plus one standard deviation. Also, in the current formula, fixed expenses are allowed to be trended. The proposed use of the above average method for determination of the efficiency standard does not allow for any future movement of those expense provisions. There should be some trend provision in the calculation of the efficiency standard. For example, the standards could be set at the trended three-year average plus one standard deviation.

Response: The existing efficiency standard uses industry averages. Therefore, a comment on that portion of the regulations is a comment on an unchanged portion of the regulations and a response is not required. As indicated elsewhere in this rulemaking file, the existing efficiency standard has worked reasonably well since its implementation in the early 1990's. An efficiency standard is commonly applied in rate regulation, and the efficiency standard was upheld in *20th Century*. The existing regulations include unallocated loss adjustment expense in the efficiency standard. The change to adjusting and other expenses merely updates the regulations to conform with changes to the annual statement terminology. The Commissioner has determined that a three-year time period strikes a reasonable balance and that allowing for one standard deviation is unnecessary. The change to fixed expenses recognizes the clarification regarding application of the efficiency standard as discussed in response to FTCR's comments above.

Commentor: Mary B. Gaillard, on behalf of AIG, September 12, 2006, page 3.

Summary: "Many insurers now utilize more than one form of marketing and distribution system for their product. As a result, a variance regarding the efficiency

standard is proposed to Section 2644.27 in order to enable insurers to reflect alternative distribution systems in their maximum and minimum earned premium calculations."

Response: The October 5, 2006, revision to section 2644.12(b) adds language providing that "For an insurer using more than one distribution system, the efficiency standard shall consist of an average weighted by earned premium for each distribution system."

Commentor: William K. Johanneson, on behalf of Farmers Insurance Group, September 13, 2006, pages 1, 5.

Summary: This section should be removed from the regulations for several reasons.

First, under the proposal, there is no longer a maximum fixed expense provision allowing for fluctuation around the efficiency standard. As the proposed regulation currently stands, it serves to reduce the spread between the maximum and minimum permitted earned premiums in some cases and therefore increases the likelihood that insurers will need to apply for a variance on the efficiency standard, thus diverting attention towards justification of current carrier-specific expenses, rather than improving efficiency.

The variance that allows for a higher level of expenses due to objective measures of above-average customer service is unrealistic because there is little correlation between customer satisfaction and efficiency.

By limiting the filed expense provision to the industry average, it creates artificial pressure on expenses for carriers that operate at a high expense level because it forces high expense carriers to reduce claims payments or expenses to maintain the same level of profitability that they would realize without these regulations.

Low premium specialty lines that are classified under private passenger auto lines of business are unduly burdened by this standard because these specialty products have high expenses and large personal lines carriers have an incentive to provide this coverage to their customers. Therefore, by holding specialty lines to an expense standard that is more truly representative of private passenger auto coverages, it will force carriers to cease offering these products and services.

Response: To the extent the comment is suggesting repeal of the efficiency standard, that is not a comment on the changes proposed to the existing regulations, and a specific response is not required. The allegation that insurers will spend their efforts justifying their current expenses in variance applications rather than improving efficiency is speculation and a detailed response is not required, other than to note such has not occurred to date. The same is true for the comment that carriers will reduce claims payments so as not to be negatively impacted by the efficiency standard. The comment regarding the customer service variance is a comment on an unchanged portion of the regulations. A response is therefore not required. Courts have consistently upheld efficiency standards in rate regulation because regulated industries are not entitled to pass

through to their customers their inefficient expense provisions. By using the average for the efficiency standard, in many lines/distribution systems, the efficiency standard is driven by the companies selling the products referenced by the commentor. The comment is rejected.

Commentor: Pamela Pressley, on behalf of the Foundation for Taxpayer and Consumer Rights (FTCR); September 13, 2006, page 4.

Summary: It is critical that CDI set and publish the Efficiency Standard (and other remaining values) at the same time it promulgates the final amendments to these regulations so that insurers, CDI and the public will have a complete set of regulations to review rate filings.

Response: The calculations will be published after the regulations are filed with the Secretary of State so that they will be the current calculations.

Commentor: Pamela Pressley, on behalf of the Foundation for Taxpayer and Consumer Rights (FTCR); September 13, 2006, page 4;
Allan I. Schwartz on behalf of The Foundation for Taxpayer and Consumer Rights; September 13, 2006; pages 2, 7-8.

Summary: We oppose eliminating the use of a company's fixed and variable expenses in the rate calculation and requiring the use of the efficiency standard in all instances. When a company's expenses fall below the industry-wide efficiency standard expenses, the use of the efficiency standard should not be mandated because it will result in windfall profits to insurers and excessive rates for policyholders.

CDI should not take this action because:

1. The expense experience for the insurer making the rate filing is effectively ignored. In those situations where the insurer has expenses lower than the efficiency standard derived from the insurance industry experience, the use of the efficiency standard expenses in the rate level calculation will result in inflated expenses being included in the rate level calculation, a windfall profit for the insurer and excessive rates being charged to policyholders.

2. The use of a combined efficiency standard for the expense provision eliminates the distinction between fixed and variable expenses. Certain expenses such as general and other acquisition expenses are fixed while other expenses such as commissions and premium taxes are variable. The proposed regulation text does not recognize this difference. It is generally accepted that separating expenses into fixed and variable components results in a more accurate rate calculation than assuming all expenses are variable.

Response: As indicated elsewhere in this rulemaking file, the change to the efficiency standard reflects the original intent of the regulations, which, over time, has been subject to different interpretations.

Commentor: Randall Farwell on behalf of Interinsurance Exchange of the Automobile Club., September 13, 2006; page 5.

Summary: This provision retains three efficiency standards based on distribution channel. We support this approach and do not support a change to a single efficiency standard, as suggested by some other parties.

We suggest that the Department consider excluding "adjusting and other expenses" from the efficiency standard. Carriers who choose to provide a greater level of service to their insured may have higher loss adjustment expense ratios. Carriers should be able to reflect their actual expenses for this category and set prices accordingly, thus allowing consumers to determine if the additional service is consistent with the additional cost.

Response: To the extent the comment supports the regulation, a response is not required. The existing regulations include unallocated loss adjustment expense in the efficiency standard. The change to adjusting and other expenses merely updates the regulations to conform with changes to the annual statement terminology.

Commentor: Milo Pearson and Christian Rataj, on behalf of the Pacific Association of Domestic Insurance Companies (PADIC) /National Association of Mutual Insurance Companies (NAMIC); September 12, 2006; pages 4,
David Appel on behalf of The Pacific Association of Domestic Insurance Companies/National Association of Mutual Insurance Companies; September 12, 2006; pages 8-10; Capital Insurance Group; September 12, 2006, Page 1.

Summary: Insurers already are engaging in good-faith practices designed to control and contain operating expenses. The CDI's reliance on averages as the maximums for a number of variables in the formula create a process which, over time, will systematically lead to a downward bias in insurance rates.

An efficiency standard is unfair and could lead some consumers to select insurance based upon whether an insurer meets the efficiency standard or not, and place insurers who invest more corporate resources into their business activities at a disadvantage.
The efficiency standard will discriminate against smaller California domestic insurers because of the higher expenses in California, which usually are related to the higher commissions that must be paid to compete with the larger national carriers.

The weighted average in the efficiency standard depends heavily on the data for the largest insurers in the state. Larger firms are the beneficiaries of economies of scale and scope, which allow them to spread costs over a larger revenue base and hence achieve lower expense ratios. Smaller firms that do not achieve such economies are unfairly

punished by being forced to use the efficiency standard as the maximum allowable expense provision in the rates.

This punitive treatment is exacerbated by the manner in which losses are projected in the ratemaking formula (i.e., the ratemaking formula requires insurers to use their actual losses in the formulation of rates, as to opposed to some industry average expected loss per unit of exposure. One strategy smaller insurers may rely upon to achieve reasonable profitability is to expend more resources on underwriting, risk selection, claims handling and the like, in order to achieve lower loss costs than average. However, if small insurers are able to achieve such results, the proposed regulations will not allow them to realize the benefits of the strategy, because the ratemaking formula uses actual losses (which reflect the loss cost savings attributable to higher expenses) but caps expenses at the industry average. It would certainly be appropriate for the regulations to contain provision for a variance if the insurer can demonstrate that its higher than average expenses are offset by lower than average losses.

The proposed expense standards (and rate-of-return restrictions) create a business climate that downplays creativity, incentive and investment, which encourages mediocrity and complacency in the development of product and setting of rates and discourages additional capital and coverage capacity. Such an environment is to the detriment of insurance buyers and innovative regional domestic companies and their customers.

Response: To the extent the comment is objecting to the existence and/or effect of an efficiency standard, or notes that insurers attempt to be efficient, that is not a comment on a proposed regulation change and a response is therefore not required. The argument that use of averages will lead to a downward bias in insurance rates has been raised and rejected and is not further responded to here. Comments regarding the allegation that the efficiency standard discriminates against smaller California domestic insurers have already been responded to and those responses are not repeated here. It is unclear why the commentor alleges that smaller California domestic insurers must pay higher commissions in order to compete with the large national carriers. However, the Commissioner incorporates his response to related comments set forth elsewhere in this rulemaking file – there are many large insurers which are inefficient, and many smaller insurers which are very efficient. The fact that some consumers may choose to purchase insurance from more efficient carriers is appropriate. In response to insurer comments, more and more components of the ratemaking formula are now company-specific. To the extent the commentor is objecting that losses are a company-specific factor, that comment is contrary to the majority of comments submitted in connection with this rulemaking proceeding. To the extent smaller insurers rely on better underwriting and risk selection, they benefit from the clarification set forth to the efficiency standard and already discussed in this rulemaking file. As the commentor notes, the variance set forth in section 2644.27(f)(2) may be available.

Commentor: Kent R. Keller, Roxani M. Gillespie, Robert J. Cerny, Barger & Wollen, on behalf of 21st Century Insurance Company; September 13, 2006; pages 5-8.

Summary: There should not be any efficiency standard as it deters innovation, reduces competition and compromises the rate of return.

The regulations improperly create separate efficiency standards based upon so-called different marketing systems. There should be a single efficiency standard in a given line to avoid favoring the use of independent agency distribution and hurting insurers who chose to distribute their policies in ways other than through independent agents, decreasing competition, and increasing rates, in contravention of Proposition 103.

If CDI intends to differentiate between insurer distribution systems, it should replace the proposed language with a two-tiered system (i.e., one tier for insurers distributing through independent agents and brokers and another tier for all others) that treats captive and direct insurers equally.

Response: As to the general objection to the efficiency standard, please see response to similar comments elsewhere in this rulemaking file. The comment that there should not be different efficiency standards based upon different distribution systems is not a comment on a changed portion of the regulation and a response is therefore not required.

Commentor: Michael J. D'Arelli, on behalf of Western Insurance Agents Association; September 13, 2006; page 2.

Summary: This provision unlawfully caps underwriting, adjusting, and other expenses for individual insurers. The Commissioner does not have the authority to prohibit actual expenses through the use of this cap and it is inconsistent with the law as it prohibits insurers from recouping costs associated with the transfer of risk.

CDI has not relied on any empirical data in proposing this regulation. Other than speculation and opinion, there is no reasonable justification for the assumption that expenses above CDI's preordained level are inefficient, nor is there any support for the suggestion that an average expense ratio is efficient.

Response: This comment is a general objection to the existence of an efficiency standard and is not a comment on a changed portion of the regulation. A response is therefore not required.

Commentor Michael A. Walters, Towers Perrin, on behalf of the Association of California Insurance Companies; September 13, 2006; page 16 – 17
Richard J. Roth, Jr., Bickerstaff, Whatley, Ryan & Burkhalter, Inc.; September 11, 2006; page 3

Summary: Not every company can be average or better. Some insurers have high expenses but better service, others have a long range plan to drive costs down and should be permitted a profit during the interim. Some insurers invest in underwriting and research on the expense side to keep their losses lower; if their losses are lower, why should they be restricted to the lower expense ratio of those who don't care about low

losses. The efficiency standard should be a maximum number much greater than the average. A range of permissible expense ratios would be preferable.

Response: The approach set forth in this section is similar to the approach adopted for the insurance rollbacks required by Proposition 103 and upheld by the Supreme Court in the *20th Century* case. As set forth elsewhere in this rulemaking file, insurers are entitled to earn a fair rate of return if they conduct their operations in a reasonably efficient manner. Thus, insurers may only pass on reasonable expenses to their policyholders. In appropriate circumstances, a variance related to cost of service may be available to an insurer.

Commentor Richard J. Roth, Jr., Bickerstaff, Whatley, Ryan & Burkhalter, Inc.; September 11, 2006; page 3

Summary: The efficiency standard limits marketing expenses based on whether sales are obtained through salaried agents or non-salaried other. The section references employees of the insurer selling on a direct basis. However, there are only two major direct writers, 21st Century (which writes most of its business in California) and GEICO (which writes less than 10% of its business in California). Since California is a high cost state, the two companies don't have the same cost structure. The comparison should not be with an individual East Coast insurer. This provision therefore happens to be wrong.

Response: Because of 21st Century's market share, it drives the efficiency standard for insurers selling on a direct basis in California. The comment is rejected.

Commentor Richard J. Roth, Jr., Bickerstaff, Whatley, Ryan & Burkhalter, Inc.; September 11, 2006; page 3

Summary: The reference to adjusting and other expenses has nothing to do with marketing. They are related to claim count, not direct losses incurred. Since many claims do not result in payment, these expenses do not relate to claim amount.

Response: The existing regulations include unallocated loss adjustment expense in the efficiency standard. The change to adjusting and other expenses merely updates the regulations to conform with changes to the annual statement terminology.

Commentor Richard J. Roth, Jr., Bickerstaff, Whatley, Ryan & Burkhalter, Inc.; September 11, 2006; page 3

Summary: The regulations allow the Commissioner to adopt efficiency standards separately for large and small insurers. There are significant differences in total underwriting expenses by size of insurer.

Response: Because this portion of the comment appears to be directed at an unchanged portion of the regulation text in subsection (b), no response is necessary.

Commentor Richard J. Roth, Jr., Bickerstaff, Whatley, Ryan & Burkhalter, Inc.; September 11, 2006, page 3

Summary: Because of the word "and" in item (4), it appears a California only insurer would be excluded. If an insurer satisfies (f)(2), does it also satisfy (3)?

Response: In response to comments that negative numbers skew the results, this section clarifies that negative premiums and negative losses are not included. Data of a California-only insurer is not necessarily excluded.

Commentor Shawna Ackerman, Pinnacle Actuarial Resources, Inc., on behalf of ACIC, PIFC, AIA; September 13, 2006; page 13 – 14;
Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 14 - 15

Summary: There is no basis to assume expenses above the designated level are inefficient nor is there any support for the proposition that an average expense ratio reflects efficiency. Higher expenses could be due to more and better service. Lower expenses could be due to inadequate service. What opportunity does a company have to validate the calculations these regulations require CDI to perform. It makes little sense to project that taxes, licenses, and fees will be negative. A better approach would be to assume it is a nominal amount or zero. The spreadsheets that were provided show significant movement in expense percentages year to year. The efficiency standard is, by definition, a lagging indicator and fails to react to increasing and decreasing rate levels. To the extent certain expenses are fixed, the percentage of fixed to premium will drop. And when rates drop, the percentage of fixed to premium increases and the efficiency standard may project too little expense.

Response: To the extent this is a general comment on the efficiency standard and not a comment on a changed portion of the regulation text, a response is not required. The Department has specified the manner in which the calculations will be performed and will publish the results of the calculations, allowing interested members of the public the ability to verify the calculations. The comment as to taxes, licenses, and fees has been accepted in the October 5 version of these regulations.

Commentor Shawna Ackerman, Pinnacle Actuarial Resources, Inc., on behalf of ACIC, PIFC, AIA; September 13, 2006; page 14 – 15;
Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 15

Summary: The efficiency standard should be a benchmark only, not an absolute cap. The insurance products within an annual statement line are diverse. There is no remedy for those insurance products with expense structures that are different than the majority of the annual statement line.

Response: The Commissioner disagrees that the efficiency standard should be a benchmark only. If the efficiency standard were merely a benchmark, the Commissioner would be unable to ensure that rates are not excessive. The efficiency standard restricts the ability of insurers to include in their rates certain expenses for inefficient insurers since allowing such expenses would result in rates which are excessive. As acknowledged in the *20th Century* case, and as indicated elsewhere in this rulemaking file, the law does not require that all costs associated with the insurance enterprise be recognized in the ratemaking formula, but only the reasonable costs. Setting the efficiency standard at the weighted mean does so, and was specifically upheld by the Supreme Court in *20th Century*. In addition, proposed section 2644.27(f)(3)(C) provides that an insurer is allowed a higher or lower efficiency standard due to significantly smaller or larger than average policy size. This variance should address most of the differences within an annual statement line of business.

Commentor Shawna Ackerman, Pinnacle Actuarial Resources, Inc., on behalf of ACIC, PIFC, AIA; September 13, 2006; page 15;
Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 15 - 16

Summary: The regulations note that the efficiency standard is the maximum allowable ratio. However, it is clearly an average. If it is to be used as an expense cap, a value greater than the average is appropriate to reflect the diversity of insurer operations. And CDI should reconsider allowing company-specific data for all loss adjustment expenses. Currently, ULAE is potentially capped by the efficiency standard, whereas ALAE is not subject to the efficiency standard. The manner in which a company settles losses can be a key component in how a company distinguishes itself among its competitors and may contribute to lower rates. The efficiency standard cap will act as a deterrent to increased customer service. An insurer could lower expenses by simply paying claims as they came in. But losses would be higher, contributing to a higher overall rate. The efficiency standard provides a disincentive for insurers to distinguish themselves based on service. This provision is unnecessary and lacks consistency and authority.

Response: This is a general comment objecting to the efficiency standard, and the Commissioner incorporates by reference his response to similar comments elsewhere in this rulemaking file.

Commentor Russina Sgoureva; Progressive West Insurance Company, September 13, 2006; page 8.

Summary: The use of an industry-wide average efficiency standard is inappropriate. Each insurer should be allowed to use its actual expenses in the ratemaking process.

Response: There is nothing in the law that prevents the Commissioner from using data reflecting the average condition and performance of the insurance industry in California as standard measurements in enforcing rate regulation as required by

Proposition 103. There is nothing in the law to prevent the Commissioner from application of an efficiency standard where doing so operates to define the reasonable cost of providing insurance.

Commentor Russina Sgoureva; Progressive West Insurance Company, September 13, 2006; page 8.

Summary: The efficiency standard prohibits insurers from recovering all of their legitimate expenses.

Response: As indicated elsewhere in this rulemaking file, and acknowledged in the *20th Century* case, a rate regulation system may permissibly limit the expenses a regulated firm may pass on to its customers.

Commentor Russina Sgoureva; Progressive West Insurance Company, September 13, 2006; page 8

Summary: The use of an efficiency standard will cause the average allowable expenses as dictated by the efficiency standard to decrease over time. Insurers should not be held to industry-wide averages but only to 80%. Using the approach of the regulations fails to consider company variations. Higher expense levels may result in better service.

The efficiency standard caps expenses and fails to take into consideration the differences between companies. Insurers writing lower limits are punished by the efficiency standard while insurers writing higher limits are reward because they have more premium over which to "spread expenses." The efficiency standard should be eliminated.

Response: Please see response to similar comments elsewhere in this rulemaking file.

Commentor Russina Sgoureva; Progressive West Insurance Company, September 13, 2006; page 8

Summary: It is appropriate that the efficiency standard recognize the three different distribution channels.

Response: The comment supports the proposed regulation.

Commentor Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 10 - 11

Summary: The proposal establishes a mechanical updating mechanism for determining the efficiency standards. The three distribution system language is retained. It appears the intent of (c) and (d) is to compute an arithmetic three year average for each insurer and then compute the weighted mean of the three year average insurer expense ratios. However, the language is somewhat ambiguous. The first four insurer criteria simply require that the insurer be actively writing in California. The fifth criteria

deliberately excludes insurers with very high expense ratios. In conjunction with the use of the average as the maximum, this creates low-ball values in which the maximum is actually set below the average. The efficiency standard approach has two significant problems.

Setting the average as the cap creates a significant downward bias in the rate review process. There is no size adjustment in the efficiency standards. The expense levels of a few, very large insurers will set the standard in some lines, resulting in automatic expense disallowances for the vast majority of insurers in the market. This will create an unlevel playing field with the resulting disincentives to enter or remain in the California market.

A number of annual statement lines encompass a wide range of insurance products. An insurer which writes coverage that is atypical of the line may experience large expense disallowances, even though its operations are efficient. The Commissioner "may" set separate efficiency standards for lines combining personal and commercial exposures. But this does not address the problems posed by atypical books, in lines that do not include both personal and commercial coverages.

The superior service variance does not address these problems. It is unclear what proof an insurer must provide regarding its quality of service. And the variance does not address an insurer which simply writes coverage that is atypical of the line as a whole. The regulation should instead provide for a cap set at a higher percentile than the average and an efficiency standard variance for coverages that are not typical of the line as a whole should be added.

The efficiency standards are biased against small insurers and small market share insurers which tend to have higher than average expenses. The regulation permits but does not require the Commissioner to promulgate separate efficiency standards for insurers writing large and small amounts of insurance in a given line. It should be amended to require an efficiency standard for small market share insurers.

Response: To the extent the comment is the same as or similar to other comments summarized in this rulemaking file, the Commissioner incorporates his responses to those comments herein. To the extent the comment supports the regulation, or is commenting on an unchanged portion of the regulation, a specific response is not required. The proof required for the superior service variance is unchanged. Therefore, a response is not required for that portion of the comment. In addition, proposed section 2644.27(f)(3)(C) provides that an insurer is allowed a higher or lower efficiency standard due to significantly smaller or larger than average policy size. This variance should address most of the differences within an annual statement line of business.

Section 2644.15 Profit Factors

Commentor Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 11

Summary: The amendment to this section is appropriate.

Response: Because this comment is supporting the proposed change, a specific response is not required.

Section 2644.16 Rate of Return

The summaries of and responses to comments regarding section 2644.16 are included at the end of this document.

Section 2644.17 Leverage Factor and Surplus

In the revised regulations, "Leverage factor" means the ratio of earned premiums to the average of year-beginning and year-end surplus.

Unlike many businesses, the insurer's need for capital is not to obtain physical plant and equipment; rather, capital is required mainly to stand behind the policy should losses exceed the amounts the insurer has set aside in reserves to meet the anticipated payouts.

In the insurance industry, by longstanding convention, the need for capital is measured by "leverage ratios," which prescribe how much insurance (measured in dollars of premium) may be sold in a given line for each dollar of surplus held by the insurer.

It is a fundamental principle of ratemaking that "just compensation" safeguarded by the Constitution is a reasonable return on the fair value of the owner's property at the time the property is being used for public service. (*Denver Union Stock Yard Company* v. *United States* (1938) 304 U.S. 470; *Los Angeles Gas & Elec. Corp.* v. *Railroad Com'n* (1933) 289 U.S. 266; *Contra Costa Water Company* v. *Oakland* (1911) 159 Cal. 323, 334.) Thus, the return that a regulated company is entitled to earn relates only to the investment or capital that is presently being employed in the public service. (*Bluefield Company* v. *Pub. Serv. Comm.* (1923) 262 U.S. 679.) Only when the investors' capital is actually "used and useful" in that public service must it be included in the rate base for determining a "fair return," and the burden is on the company to show that the property is truly "used and useful." (*Barasch* v. *Pennsylvania Pub. Util. Com'n* (1987) 516 Pa. 142, 532 A.2d 325, aff'd sub nom. *Duquesne Light Company* v. *Barasch*, 488 U.S. 299.)

Application of this principle to the insurance business requires the Commissioner to determine the amount of capital that is actually used and useful to support an insurer's operations, and on which the insurer is therefore entitled to earn a return from its policyholders. (See *Denver Union Stock Yard Company* v. *United States* (1932) 57 F.2d 735, 740-41 (power to set rate which is not confiscatory necessarily implies power to determine value of property used and useful in providing the public service).)

The application of industry-wide leverage factors calculated by the Commissioner was upheld in *20th Century.* The court stated: [T]the leverage factor is crucial to the determination of rates. *20th Century,* 8 Cal. 4th 216, 309; 32 Cal. Rptr. 807, 867. According to the Court, "The leverage factor functions as an application of the 'used and useful' rule. That rule is a 'permissible' 'tool[] of ratemaking' under the takings clause."

(Quoting *Jersey Cent. Power & Light Company v. F.E.R.C.) 20th Century*, 8 Cal. 4th 216, 309; 32 Cal. Rptr. 807, 867.

Commentor Mary B. Gaillard, on behalf of AIG, September 12, 2006, page 4.

Summary: The use of industry average leverage ratios may not be reflective of riskier classes of business and the capital dedicated to providing sufficient financial strength.

Response: In proposed § 2644.17, in subsection (c) the Commissioner specifically finds that risk varies from line to line. The proposed regulations account for risk variations by line of business by calculating the leverage ratios by line. Until such time as the factors are actually calculated whether the leverage factors are reflective of risk in a given line is speculative. To the extent the comment relates to unchanged portions of the regulation, a response is not required.

Commentor Mary B. Gaillard, on behalf of AIG, September 12, 2006, page 4.

Summary: An exception for specialty lines should be made to allow for company-specific leverage ratios to be used as calculated by the insurer. A variance should be added to allow insurers to calculate and apply company-specific leverage factors for all lines of insurance not just specialty lines.

Response: In response to this and other similar request the regulations were revised. The proposed regulations provide that rates for specialty insurance shall be approved or disapproved using the most sound actuarial method, consistent with California law, in accordance with the Actuarial Standards of Practice, and relevant and accepted actuarial principles, guidelines, and literature.

As stated previously, it is a fundamental principle of ratemaking that "just compensation" safeguarded by the Constitution is a reasonable return on the fair value of the owner's property at the time the property is being used for public service. Application of this principle to the insurance business requires the Commissioner to determine the amount of capital that is actually used and useful to support an insurer's operations, and on which the insurer is therefore entitled to earn a return from its policyholders

The regulations are designed to allow an insurer the opportunity to earn a fair return on capital. However, the regulations must, as a practical matter, measure that return. The leverage ratios are an integral part of this test for reasonableness as the Commissioner is determining the amount of capital that is actually used and useful to policyholders. Insurers are allowed a fair return on the used and useful portion of surplus. Insurer may not earn the same return on capital that is not used and useful to policyholders.

Target return, investment income and leverage are interrelated. These factors interact and allow the Commissioner to test the reasonableness of the insurer's return on capitol.

Commentor William K. Johanneson on behalf of Farmers Insurance Group, September 13, 2006; pages 5-7.

Note: These comments are made under the heading of *Rate of Return/Leverage Factor and Surplus.* The summaries and responses in this section relate to leverage factor and surplus only. Rate of return comments are responded to in the rate of return section of this document.

Summary: The Commissioner does not recognize that rates of return vary by lines of business.

Response: In proposed § 2644.17, in subsection (c) the Commissioner specifically finds that risk varies from line to line. The proposed regulations account for risk variations by line of business by calculating the leverage ratios by line. The Commissioner rejects the comment that the rate of return must be set, by line. However, as the Commissioner recognizes that riskier lines of insurance may require higher return by setting leverage ratios by line the Commissioner allows for more capital to be "used and useful" for those riskier lines, thereby increasing the allowable profit to be garnered from those lines. For these reasons the comment is rejected.

Commentor William K. Johanneson on behalf of Farmers Insurance Group, September 13, 2006; page 5-7.

Note: These comments are made under the heading of *Rate of Return/Leverage Factor and Surplus.* The summaries and responses in this section relate to leverage factor and surplus only. Rate of return comments are responded to in the rate of return section of this document.

Summary: The use of industry-wide leverage and surplus factors punishes highly capitalized companies by artificially suppressing their rates of return. Where insurers have a greater capital base a greater level of protection is afforded on claims payments to its policyholders.

Response: As stated previously, it is a fundamental principle of ratemaking that "just compensation" safeguarded by the Constitution is a reasonable return on the fair value of the owner's property at the time the property is being used for public service. Application of this principle to the insurance business requires the Commissioner to determine the amount of capital that is actually used and useful to support an insurer's operations, and on which the insurer is therefore entitled to earn a return from its policyholders

The comment suggests that all capital, even that greater than that "used and useful" should be recognized in the rate of return formula. Again, an insurer is entitled to a profit only on the capital it has actually applied to providing insurance. The measure of that capital is not the theoretical risk of future loss which that capital may be exposed but the actual amount at risk. One could take any insurer, double its surplus, and have an amount that is theoretically at risk. Double it again, and the new amount is likewise theoretically

at risk. The fact that this process can be repeated infinitely without the argument losing any of its logical force demonstrates that it fails to capture the economic reality of the insurance business.

The regulations require the Commissioner to determine the amount of capital that is actually required to stand behind the insurance obligation. Claims that a (potentially infinite) additional amount would have theoretical or legal exposure are irrelevant and unconvincing. Riskier lines are allowed a different leverage ratio than less risky lines to reflect that difference in risk.

Commentor Alan I. Schwartz on behalf of The Foundation for Taxpayer and Consumer Rights, September 13, 2006; page 4.

Summary: It is critical that the Commissioner set and publish this value (and other remaining factors required to be set by him) at the same time he promulgates the final amendments to these regulations so that insurers, CDI and the public will have a complete set of regulations to review rate filings.

Response: The regulation sets forth the source data which the Department will use for the leverage ratios. The numbers will be updated annually. It would be inefficient to calculate those until such time as the regulations are filed with the Secretary of State. However, they will be calculated and published at that time.

Commentor Randall Farwell on behalf of Interinsurance Exchange of the Automobile Club., September 13, 2006; page 6.

Summary: The leverage ratios are too restrictive. The leverage ratios do not reflect the risk being assumed by the Exchange. Imposing an industry average will require the Exchange to use unreasonably high leverage ratios, which is not in the best interest of our insureds who expect us to maintain our strong surplus position. Our business is highly concentrated in California and because of the potential catastrophic losses we need to maintain an exceptionally strong surplus to protect our insureds and assure that we can meet their expectations for prompt and full claims payment in the event of large unexpected losses.

Response: Only that surplus that is "used and useful" is recognized in terms of the allowable return on equity. This does not mean that insurers may not employ different leverage factors or build up excess surplus. The regulations use imputed leverage factors to measure the reasonableness of the insurer's return. They do not require insurers to employ those same leverage factors.

As to the flexibility of the approach, the Commissioner has determined that application of industry-wide averages for leverage factors enhances consistency and makes manageable the job of rate regulation. Many revisions have been made to the current regulations to allow for greater flexibility. To allow insurers the use of company-specific data for every factor in the ratemaking formula would eviscerate the regulatory scheme and render the

job of rate regulation impossible. In order to make the job manageable and to provide for a reasonable level of consistency the limited use of some industry-averages is both reasonable and necessary.

However, to address similar comments, the Commissioner has revised the variance set forth in section 2644.27(f)(5) for an insurer highly concentrated in California or in a line.

Commentor: David Appel on behalf of The Pacific Association of Domestic Insurance Companies/National Association of Mutual Insurance Companies; September 12, 2006; page 7.

Summary: Current industry-wide surplus level is substantially higher than the 30-year average. The current industry average is roughly 40% greater than the average level over the last 30 years. If the industry's current surplus position was equal to the historical average, industry risk and required return would be significantly higher than it currently is.

Response: In response to this and similar comments the 30 years average approach was revised in favor of an annual average based on the most recent data available, as specified in the regulation.

Commentor: David Appel on behalf of The Pacific Association of Domestic Insurance Companies/National Association of Mutual Insurance Companies; September 12, 2006; page 7.

Summary: Using industry wide ratios is particularly punitive to smaller insurers. Larger insurers are substantially diversified, selling multiple lines of business. This diversification confers benefits in terms of risk reduction which allows these large companies to have decreased surplus requirements. Smaller insurers that write a limited number of lines cannot obtain these benefits and must therefore keep their surplus level higher. Ratios calculated using industry averages may result in ratios inadequate for these smaller insurers.

Response: This is generally the approach employed in the existing regulations and upheld in *20th Century.*

It should also be noted that the regulations do not contain any surplus requirements. The regulations merely impute surplus in relation to a measure of the reasonable return.

No compelling evidence leads the Commissioner to believe any appreciable number of insurers in California are so small and have a mix of business so one-dimensional that it makes these surplus requirements unfair or unconstitutional. The variances found in sections 2644.27(f)(5), 2644.27(f)(6) and 2644.27(f)(7), among others, may already apply.

Commentor: David Appel on behalf of The Pacific Association of Domestic Insurance

Companies/National Association of Mutual Insurance Companies; September 12, 2006; page 7.

Summary: Smaller insurers purchase reinsurance to "make up the difference" relative to these "benefits of diversification" enjoyed by larger companies by purchasing reinsurance. However, as there is no allowance for reinsurance in the ratemaking formula smaller companies are at a disadvantage.

Response: The revised regulations specifically allow consideration of reinsurance for earthquake and specified medical malpractice coverage. No compelling evidence leads the Commissioner to believe any appreciable number of insurers in California are so small and have a mix of business so one dimensional that it results in surplus requirements so unfair as to warrant special treatment as contemplated in this comment. The existing regulation does not distinguish leverage ratios based on large versus small insurers. This comment appears to be directed at an unchanged portion of the regulations and a response is not required.

Commentor: Kent R. Keller, Roxani M. Gillespie, Robert J. Cerny, Barger & Wollen, on behalf of 21st Century Insurance Company; September 13, 2006; page 10.

Summary: Industry-wide averages discourage insurers that believe it is a benefit to consumers to be conservatively capitalized. Such insurers will not receive the benefit of investing the necessary funds in California to support those conservative principals.

Response: To the extent "conservatively" means over capitalized, it is well established in the law that the opportunity to earn a fair rate of return refers to a reasonable return on the fair value of the owner's property at the time the property is being used for public service. Application of this principle to the insurance business requires the Commissioner to determine the amount of capital that is actually used and useful to support an insurer's operations, and on which the insurer is therefore entitled to earn a return from its policyholders. With that said, only that surplus that is used and useful will be recognized. Additionally, to the extent this comment relates to an unchanged portion of the regulation text, a response is not required.

Commentor: Kent R. Keller, Roxani M. Gillespie, Robert J. Cerny, Barger & Wollen, on behalf of 21st Century Insurance Company; September 13, 2006; page 10.

Summary: The use of industry-wide averages also unfairly discriminates against speciality insurers, such as 21st Century, which is concentrated in California or in a particular line of business. Such concentration poses an additional investment risk. For concentrated insurers, especially those like 21st Century that are publicly traded, the regulations provide an incentive for investment elsewhere, both to spread risk and to attain the benefit of maintaining conservative capitalization.

Response: The Commissioner notes that a variance is recognized in section 2644.27(f)(f) for an insurer concentrated in one line or in California.

Commentor Michael A. Walters, Towers Perrin, on behalf of the Association of California Insurance Companies; September 13, 2006; page 17.

Summary: This is a complex subject, not easily resolved with the simplistic rules proposed.

Response: Because the comment is general in nature, the Commissioner is unable to provide a specific response. The Commissioner believes that the regulation represents a typical premium to surplus calculation and maintains that the regulation is an appropriate method to regulate the premium to surplus ratios of insurers. The Commissioner notes that this regulation is similar to the leverage factor provision adopted for the insurance rate rollbacks which was upheld by the Supreme Court

Commentor Michael A. Walters, Towers Perrin, on behalf of the Association of California Insurance Companies; September 13, 2006; page 17 – 18.

Summary: Catastrophe lines have little loss reserves compared to most lines, but the amount of risk and necessary surplus is much greater than the typical line of business. Even a 1.0 ratio for earthquake may understate the surplus needed.

Response: The Commissioner realizes that the earthquake line presents higher risk than some other lines, and that fact should be reflected in the leverage factor established for that line. However, the Commissioner has determined that a 1.0 leverage factor for the earthquake line appropriately balances the need of both insurers and policyholders. A 1.0 leverage ratio recognizes that a larger amount of capital is devoted to providing earthquake insurance, which of course produces higher rates. At the same time, if the leverage factor is too high, policyholders will be required to provide a return on capital which is not actually employed for the insurance business. Based upon the evidence provided, the Commissioner's July 14, 2006, decision (In the Matter of the Rate Applications of First National Insurance Company of America, SAFECO Insurance Company of America, and SAFECO Insurance Company of Illinois, File No. PA04041210) adopted a leverage factor of .97 to 1. The number set forth in these regulations is in keeping with the reasoning underlying that decision, yet allows insurers a slightly higher premium to surplus ratio.

Commentor Richard J. Roth, Jr., Bickerstaff, Whatley, Ryan & Burkhalter, Inc.; September 11, 2006, page 4.

Summary: The current ratio for earthquake is 2.0. The proposal is 1.0. It would be better not to prescribe a leverage factor for earthquake.

Response: Section 2645.6(b) of the Department's regulations, applicable to rate rollbacks, established an earthquake leverage factor of 2.00 to 1. Since that time, in review of company-specific rate applications, the Commissioner has determined that a lower leverage factor (resulting in higher rates to policyholders) is appropriate,

recognizing the earthquake losses, and potential for losses, that insurers have experienced since the rollback regulations were first promulgated approximately 15 years ago. The currently proposed regulations set an earthquake leverage factor of 1.0. The Commissioner has determined it is appropriate to set forth the leverage factor in the regulations so interested members of the public will know what factor the Commissioner will apply in reviewing rate applications. Additionally, not including any leverage factor for earthquake subjects the Commissioner to a potential challenge under California Government Code Section 11340.5, since the Commissioner obviously must allow a leverage factor when reviewing earthquake rate applications.

Commentor Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 14 – 15.

Summary: The 30 year averaging process is not appropriate.

Response: In response to comments, the regulation has been amended and the 30-year average has been deleted.

Commentor Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 15

Summary: The regulations allocate surplus to lines based on the ratio of "national" unearned premium reserves, loss reserves and loss adjusting expense reserves. "National" is not defined and it is unclear whether state-run insurance programs are included. It is unclear how the Department will determine the 30-year average.

Response: The regulations have been revised to specify that the data used in the leverage calculation is as set forth in Best's Aggregates and Averages. A further definition is not necessary. The reference to "national" is intended to distinguish the data from California-only data. As indicated above, the 30-year average has been deleted from the regulations in response to public comments.

Commentor Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 15 - 16

Summary: The regulation does not use current leverage, as demonstrated by a worksheet provided during the most recent workshop. For a line which currently has the typical industry-wide all lines average line leverage, the effect of the formula is to minimize the effect of the current data and substitute a higher leverage (less surplus) using the 30-year average industry leverage. For a line with a current higher than average leverage, the effect of the formula is to generate a leverage factor that is significantly inflated.

The effect of the formula is to give very little weight to current leverage ratios relative to the long term average; to artificially inflate the leverage ratio; and to reduce the amount

of surplus used to meet the maximum and minimum premium requirements of 2644.2 and 2644.3, resulting in inadequate rates under current conditions.

Leverage ratios have dropped across the board over the last 30 years; more capital is needed to support each dollar of premium written. A current leverage ratio of 1.10 should be used; otherwise inadequate rates are the result. Using an 11% rate of return for a company with a premium to surplus ratio of 2:1 results in a profit per premium dollar of .055. Using the 2.7 ratio produces a profit per premium dollar of .041, which corresponds to an 8.2% rate of return. Reduced leverage benefits consumers through lower risk of insolvencies.

Response: The 30-year average has been deleted in response to comments such as these.

Commentor Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 16 - 17

Summary: Using industry average leverage for Other Liability and other lines with diverse risks is inappropriate because Other Liability includes many different types of products and it is arbitrary to assume the same leverage factor for all products in this category. An example is given of an insurer writing virtually all of its Other Liability as general liability for contractors. The regulation should specify that the insurer can offer and the Commissioner can accept a different leverage ratio than is provided, upon a showing that the risks written differ from the industry average distribution of risks used in the computation of the promulgated factors. Oregon Mutual is a small insurer that writes its own earthquake coverage. Its current earthquake leverage is 0.5. A leverage factor of 1 does not represent the true risk. The source of this ratio is not indicated. A small insurer writing earthquake needs to allocate more than the industry average to this catastrophe line. The regulations should allow a variance to the earthquake leverage ratio for small insurers.

Response: As to calculation of the leverage ratio for earthquake, please see the response to similar comments elsewhere in this rulemaking file. Differences in risk within a line that are not reflected by using the same leverage are largely cancelled out by also using the same reserve ratio. Additionally, the regulations now allow consideration of reinsurance costs for the earthquake line. The comment as to other liability is rejected. For other liability, there shall be separate leverage factors for claims-made and occurrence, which reflects the different coverages offered in this line. The Commissioner has determined that using an average adequately reflects the various coverages offered in this line.

Commentor Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 17

Summary: Subsection (c) states that "[t]he Commissioner finds that investors' perceived investment risks may vary from line to line. Thus, while the rate of return does

not vary by line, insurance perceived to have a greater risk will yield higher returns per premium dollar." This statement is garbled, contradicted by the suppression of actual leverage ratios and adds nothing of substance to the regulations. It should be deleted.

Response: Current section 2644.17(c) provides as follows:

> (c) The Commissioner finds that investors' perceived investment risk may vary from line to line. In lines perceived to have higher-risk, the Commissioner may establish, in accordance with section 2646.3, higher surplus requirements, and insurers may earn the rate of return on the higher surplus. Thus, while the rate of return does not vary by line, insurance perceived to have a greater risk will yield higher returns per premium dollar.

The regulations have been revised to delete the 30-year average. Therefore, the concern regarding suppression of actual leverages has been addressed. The second sentence of this section is proposed for deletion because leverage factors will no longer be determined in accordance with section 2646.3. The Commissioner believes that deletion of the second sentence from this section does not make the section garbled. The commentor does not explain why this sentence is garbled. Additionally, this comment is generally directed at an unchanged portion of the existing regulations, and therefore a detailed response is not required.

Section 2644.18 Federal Income Tax Factors

The proposed regulations recognize Federal income tax and in so doing provide an off-set in the ratemaking formula.

Commentor: William K. Johanneson on behalf of Farmers, September 13, 2006; page 7

Summary: The proposed language is greatly improved.

Response: The comment generally supports the regulation. Therefore, no response is required.

Commentor: Allan I. Schwartz, on behalf of the Foundation for Taxpayer and Consumer Rights; September 13, 2006; page 9.

Summary: The tax rate of 34.1% on stock capital gains is excessive and does not fully reflect the deferral of taxes on unrealized capital gains or the tax planning used by insurance companies to shield capital gains from taxes. The Massachusetts Division of Insurance has examined this issue in dept for many years in the context of the annual private passenger automobile insurance rate proceedings and has consistently concluded that the appropriate tax rate to use to stock capital gains is 17.5%.

Response: Testimony from the Massachusetts automobile hearing supports the 34.1%. The Massachusetts decision provides no justification for the selection of 17.5%. The Commissioner disagrees with this aspect of the Massachusetts decision.

Commentor: Allan I. Schwartz, on behalf of the Foundation for Taxpayer and Consumer Rights; September 13, 2006; page 9.

Summary: Realized capital gains have a tax rate of 35%. Unrealized capital gains have a tax rate of 0%. The use of a 34.1% tax rate implies that about 97% of capital gains are realized and only about 3% are unrealized. This is an unrealistic result, since the magnitude of the realized and unrealized capital gains can be expected to be generally comparable. The use of an equal division of capital gains into realized and unrealized portions gives a tax rate of 17.5%.

Response: The 34.1% recognizes that taxes will be paid at the 35% rate in future years when unrealized gains are finally realized. The 34.1% rate is the discounted present value of the future 35% rate.

Commentor: Shawna Ackerman, Pinnacle Actuarial Resources, Inc., on behalf of ACIC, PIFC, AIA; September 13, 2006; page 15 – 16;
Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 16

Summary: The proposed regulation refers to the specific current tax rate. To keep this section current and prospective, reference should be made to the current federal income tax rates without specifically listing values.

Response: The Department has not adopted this comment. Because the specific tax rate numbers rarely change, the Department believes the regulation is clearer if the specific number is set forth.

Commentor Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 17

Summary: The commentor supports the changed proposed to this section.

Response: A specific response is not required.

Section 2644.19 Investment Income Factors

Cal. Ins. Code Section 1861.05(a) explicitly requires that investment income be considered in the ratemaking formula where it provides that in considering the reasonableness of a rate: "[T]he commissioner shall consider whether the rate mathematically reflects the insurance company's investment income. In *20th Century* the Court had no objection to the use of this factor in the regulations. The Court held: "The

rate regulations are also sound insofar as they recognize investment income in the ratemaking formula." *20th Century,* 8 Cal. 4th 216, 258; 32 Cal. Rptr. 807, 833.

Commentor: William K. Johanneson on behalf of Farmers, September 13, 2006; page 7

Summary: The proposed revisions to this section contain an implicit assumption that loss and DCCE reserves be supported solely by fixed income and that Unearned Premium Reserve (UEPR) and surplus be supported solely by equity. Such a structure creates disincentives for companies to provide their policyholders with a more stable and trusting financial structure that is leveraged heavier in fixed income. As such we request that a variance be allowed for the fixed and variable investment income factors due to the capital structure of the insurance company.

Response: The regulations impose no requirements on insurers as to whether the insurer is "leveraged heavier in fixed income" or not. The regulations are designed to assess the reasonableness of the insurer's rates.

There is no assumption underlying the investment income factors that loss and DCCE reserves are supported solely by fixed income and that Unearned Premium Reserve (UEPR) and surplus be supported solely by equity. "Fixed" as used in the regulations here means "does not vary directly with premium as a matter of contract or law", not "fixed" as in fixed income, such as interest on bonds. UEPR is a function of premium and the amount of dollars available for investment will vary by premium. As such it is properly recognized.

The costs are fully recognized and factored into the investment income calculation.

The two principal types of reserves established by insurance companies are loss (or claim) reserves and unearned premium reserves. Unearned premium reserves represent that portion of the premium that has not been earned or used up at any particular time. Investment income is earned on UEPR. UEPR necessarily varies with premium.

Investment income is also earned on loss reserves and DCCE impacts loss reserves. In order to get a true picture of investment income these two items must be taken into consideration.

DCCE represents all claim defense costs and claim cost containment expenses but it does not include costs associated with adjusting claims. Traditionally these costs have not been treated as varying directly with premium as a matter of contract or law.

Commentor: Richard J. Roth, Jr., Bickerstaff, Whatley, Ryan & Burkhalter, Inc.; September 11, 2006, page 5

Summary: This new section develops new formulas for fixed and variable income factors. It is a new procedure in ratemaking, and it is not clear that it produces a better result. It is more complicated and will only work if all of the reserves and surplus are

included in Invested Assets. This is not always the case, especially for weak companies. The biggest problem is that the yield is an average only.

Response: Section 2644.20 provides that the yield for each asset class shall be based on an average of the most recent available three complete months. It is not a new procedure in ratemaking. The Department of Insurance has used a very similar formula for the California Automobile Assigned Risk Plan and the California Automobile Insurance Plan for many years. The only realistic way to account for yield is as an average, since using the specific yield at any particular point in time may result in an anomalous result. Distinguishing fixed and variable income factors was supported during the workshop process. The Commissioner has determined that it does produce a better result. The fact that it may be more complicated should not be determinative. Potential differences between the sum of reserves and surplus and invested assets are addressed in the yield calculation in section 2644.20(f).

Commentor: Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 17

Summary: The commentor appears to support the changes proposed to this section.

Response: A specific response is not required.

Section 2644.20 Projected Yield

Commentor: William K. Johanneson, on behalf of Farmers Insurance Group, September 13, 2006, pages 1, 7.

Summary: We are concerned that the changes to the projected yield require use of new money rates. This is not accurate for companies whose portfolios are made up of securities with varying maturities in which case the portfolio yield is more appropriate. As a result, this change does not serve to award or penalize insurers for the quality of their own past investment strategies. With the introduction of a variance process, we recommend that this area be included as a valid basis for variance.

Response: It is generally agreed that ratemaking should be prospective. The Commissioner has determined that new money rates are prospective and therefore this is the most appropriate manner in which to reflect investment yield.

Commentor: Allan I. Schwartz on behalf of The Foundation for Taxpayer and Consumer Rights; September 13, 2006; page 10.

Summary: The term length definitions proposed by CDI for short, intermediate and long term bonds reasonably reflect the time period that insurers hold these assets, and are appropriate to use in calculating the investment yield.

Response: Because this comment supports the regulation, a specific response is not required.

Commentor: Randal Farwell on behalf of Interinsurance Exchange; September 13, 2006, pages 2, 6-8.

Summary: Implementing the proposal will generate a change from the imbedded portfolio yield to a market yield. Given that our investment portfolio for policyholder surplus is heavily invested in bonds, we believe there needs to be more flexibility in the calculation. The use of the imbedded yield (current regulation) is a better choice than the market yield, because the market yield assumes that the investor is constantly liquidating and reinvesting their capital. This is not consistent with the more conservative investment strategy used by the Exchange.

Response: It is generally agreed that ratemaking should be prospective. The Commissioner has determined that new money rates are prospective and therefore the proposed regulation is the most appropriate manner in which to reflect investment yield. When interest rates are rising, as they are now, the new money yields will be higher than the imbedded yields; however, when interest rates are falling, the opposite will be true.

Commentor: Randal Farwell on behalf of Interinsurance Exchange; September 13, 2006, pages 2, 6-8.

Summary: Should CDI decide to use the market yield method, it should make a number of changes. The sentence "The yields for each asset class shall be based on an average of the most recent available 3 complete months, as of the date of the filing: is somewhat ambiguous. Does this mean the average of the yields on the 3 most recent month-end dates, or should 3 months of daily yield be used, if available? If the 3 most recent month-end dates should be used, but an item is only published weekly, should the weekly dates that are closest to month-end be used?

Response: The Commissioner disagrees that this sentence is ambiguous and has not proposed changes to this sentence.

Commentor: Randal Farwell on behalf of Interinsurance Exchange; September 13, 2006, pages 2, 6-8.

Summary: The proposal defines intermediate-term bonds as 1-year through 10-year bonds, but selects the 10-year bond to represent the yield of the category, which is at the far end of the range of maturities. A 5-year or 7-year bond would appear to be more appropriate, or even an average of the 1, 3, 5, 7 and 10-year bonds.

The same concern applies to tax-exempt bonds.

Response: The Commissioner has determined that the currently-proposed language is appropriate. The annual statement category of 1-year through 10-year represents the

remaining maturity from the date of the annual statement, not from the issue date of the bond. Assuming that companies hold bonds from the issue date to final maturity, the average remaining maturity will be half the total maturity from issue date. Therefore there is no mismatch.

Commentor: Randal Farwell on behalf of Interinsurance Exchange; September 13, 2006, pages 2, 6-8.

Summary: We are not familiar with ValuBond. Typing Yahoo.com/ValuBond into a Web browser does not result in a valid Web site. Bond yields can be found at yahoo.com that are currently supplied by ValuBond, however. The Web site shows yields from today, yesterday, last week and last month. We could not find historical data, so the Department would need to check periodically over time and publish the yields for future use. The "Last Month" yield does not specify whether it is the month-end yield or the average over the month. It is not clear what should be used if Yahoo stops providing ValuBond data or stops providing the data altogether. The proposal includes both A and AA rated bonds, however, Yahoo does not provide a category for both ratings together. The two yields could be averaged, but it would not necessarily represent the mix of the two ratings that is available in the market.

Response: The regulation has been changed in response to this comment. Averaging the maturities was proposed by commentors in the workshops.

Commentor: Randal Farwell on behalf of Interinsurance Exchange; September 13, 2006, pages 2, 6-8.

Summary: Capital gains are not normally included in a yield calculation, so it is not clear why they should be included in the calculation of the projected yield. If the projected yield is intended as a measure of expected rate of return on investments, then capital gains would be included; however, the proposed formula appears to result in estimates that are too high, due to an extremely high risk premium of 8%. A risk premium of 2% to 3% would appear to be more appropriate for ratemaking.

Response: The Commissioner has determined that the existing language is appropriate. A risk premium of 8% is not "extremely high," as is clear from the comments on rate of return.

Commentor: Randal Farwell on behalf of Interinsurance Exchange; September 13, 2006, pages 2, 6-8.

Summary: The proposal does not state exactly what is to be used from the Mergent Bond Record with which we are unfamiliar. We could not find anything on the Web site that might be useful in fulfilling this requirement.

Response: The Commissioner has not adopted this comment. The Mergent Bond record is a comprehensive and authoritative resource. This source was recommended by commentors in the workshop and was selected in the Massachusetts auto decision.

Commentor: Randal Farwell on behalf of Interinsurance Exchange; September 13, 2006, pages 2, 6-8.

Summary: The risk premium of 2% for real estate appears to be too high; it should be 0% instead. We do not purchase real estate for investment purposes, but rather for the purpose of servicing our members, so decisions are not based on maximizing our return on equity. Similar to other assets that are used in the course of business, such as computers and furniture, this real estate does not generally produce investment income.

Response: The Commissioner disagrees that 2% is too high. Two percent was selected after a thorough review of the Massachusetts auto decision and comments made in the workshop.

Commentor: Randal Farwell on behalf of Interinsurance Exchange; September 13, 2006, pages 2, 6-8.

Summary: Receivables for securities should be included in this category, since cash will be received when the sale of the security settles. The proposal appears to place these receivables with "Other," which is a common stock yield and is inappropriate for cash.

Response: The procedure for receivables was determined after a thorough review of the Massachusetts auto decision and comments made in the workshop.

Commentor: Randal Farwell on behalf of Interinsurance Exchange; September 13, 2006, pages 2, 6-8.

Summary: Besides receivables for securities, the "Other" category appears to include contract loans (the Exchange has none of these), other invested assets (Schedule BA) and aggregate write-ins for invested assets. The latter two items could include any asset class. Using the equity yield would be inappropriate for the first two items and biased to the high side for the last two items for most insurers. The Exchange's only Schedule BA holdings are currently all real estate funds, so a real estate yield would be more appropriate in this particular case.

Response: The procedure for receivables was determined after a thorough review of the Massachusetts auto decision and comments made in the workshop.

Commentor: Richard J. Roth, Jr., Bickerstaff, Whatley, Ryan & Burkhalter, Inc.; September 11, 2006, page 5.

Summary: The proposed language is too complicated. The original language was just fine. Most assets are invested in medium term bonds. It is almost impossible to project out to 5 or 10 years the future investment income.

Response: The changes to this regulation are intended to allow for more company-specific yield numbers than the current regulation does. While the language may be complicated, the subject matter is also complicated, and the language is no more complicated than necessary. The regulation does not require insurers or the Department to predict what future investment income will be five or ten years into the future.

Commentor Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 17 - 18

Summary: The regulation appropriately mandates use of prospective yields. Distribution of the insurer's portfolio is based on the most recent Annual Statement. However, use of consolidated Annual Statement data is inappropriate where companies not admitted in California are included in the Annual Statement. If the non-admitted company writes a different mix of business from the admitted insurer, they will have a very differently distributed portfolio and the duration of the invested assets is likely to be different.

Response: Please see response to other comments in this rulemaking file regarding use of combined data.

Commentor Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 18.

Summary: The prospective investment yield on intermediate bonds is the yield on ten year bonds. Because "intermediate" bonds include one to ten year bonds, the regulation produces upwardly biased estimates of the yield when the yield curve is in this normal upward sloping mode. The use of a five year bond for the one to 10 year bond category would cure that defect.

Response: The Commissioner has determined that the currently-proposed language is appropriate. The annual statement category of 1-year through 10-year represents the remaining maturity from the date of the annual statement, not from the issue date of the bond. Assuming that companies hold bonds from the issue date to final maturity, the average remaining maturity will be half the total maturity from issue date. Therefore there is no mismatch.

Commentor Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 18.

Summary: The use of yahoo.com/ValueBond is problematic for several specified reasons. A simple public source such as the Wall Street Journal is preferable. Since data sources may change, the regulation should provide for the use of "similar source " data.

Response: The Department believes that ValueBond is as authoritative and readily available a source as is the Wall Street Journal, which, like ValueBond, is not a government publication. Simply referencing "similar source" data is not necessarily clear, since there could be a difference of opinion as to what constitutes similar source data. If ValueBond is no longer an appropriate reference, the regulations can easily be changed to reflect a better source for the data. The Department has therefore not adopted this comment.

Commentor Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 18.

Summary: In subpart (d), medium term appears to be a misstatement of intermediate term. The return on intermediate risk free bonds is correctly determined using the five year rather than the ten year rate.

Response: The regulations have been amended to change medium to intermediate.

Commentor Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 18.

Summary: The average return for stocks is determined as the average of the risk free rates for short, intermediate and long term Treasury securities plus 8%, resulting in a current return of approximately 13%. There is a serious inconsistency between this and the 11% rate of return provided in section 2644.16. The rate of return allowed insurers is artificially depressed below the level that insurers are assumed to earn on investments of identical risk. As the investment income is credited to policyholders (and reduces premiums) while the rate of return is credited to the insurer's owners (and increases premiums) there is an obvious bias in the regulations.

Response: While commentors have argued that a particular sample of publicly traded insurers and reinsurers are of average risk, the comparison of book returns from this sample with the property-casualty industry as a whole shows that the property-csualty industry is of lower risk than the sample. Therefore there is no serious inconsistency between the return on stocks for the yield calculation and the return allowed to insurers in these regulations.

Commentor Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 18.

Summary: The provision with respect to real estate does not distinguish real estate held for income production and real estate occupied by the company. The regulations assign a yield to buildings used in the insurer's operations that produce no investment income. For small insurers, imputing income to real estate used in operation, which may be the entirely of the insurer's real estate holdings, will produce an inflated measure of investment income.

Response: This provision was selected in response to recommendations made by comentors during the workshops and after a thorough review of the Massachusetts auto decision.

Commentor Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 18 – 19.

Summary: Subpart (f) corrects the investment yield. However, at times the invested assets may exceed the sum of reserves plus surplus. In that case, the income from the excess of invested assets over reserves plus surplus should not be financially assigned to the policies written under the proposed rates. Subsection (f) should include an additional sentence "in no case should the ratio multiplier exceed 1.0."

Response: This provision was selected in response to recommendations made by comentors during the workshops and after a thorough review of the Massachusetts auto decision.

Section 2644.21 Reserves Ratio

Commentor: Mary B. Gaillard, on behalf of AIG, September 12, 2006, page 4.

Summary: The use of industry average reserve ratios would not reflect a company's overall reserving practice and philosophies. This is an integral part of the ratemaking process and should be in line with the reserves incorporated in the loss development process. In addition, the use of an industry average reserve ratio would be substantially different than the reserve ratios for many of the specialty lines. Reserve ratios should remain as a company-specific calculation. If not, then a provision should be added to the variance section for companies with significantly different reserve ratios than the industry line of business average.

For specialty lines, the exception for loss development and trend should further e expanded to include reserve ratios.

Response: Further revisions have been made in the October 5 version of these regulations as to specialty lines. Otherwise, the Commissioner has determined that use of industry-wide numbers is the most appropriate. The regulation recognizes different reserve ratios for each line of business, rather than a single reserves ratio applicable to all business written by the company. Additionally, there is now an unearned premium reserves ratio and a loss reserves ratio, rather than the current single reserves ratio. The Commissioner has determined that the proposed regulation sufficiently recognizes and reliably projects the reserves ratio for ratemaking purposes. Using an industry-wide by-line reserve ratio is consistent with using an industry-wide by-line leverage ratio. For the third workshop, an alternative regulation was offered that would have allowed company-specific reserve ratios, but the alternative did not receive any favorable comments.

Commentor: William K. Johanneson, on behalf of Farmers Insurance Group, September 13, 2006, page 7.

Summary: CDI should allow for the use of company-specific data in these calculations, as this data is readily available, accurate, and easily verifiable.

Response: Please see response to similar comment above.

Commentor Richard J. Roth, Jr., Bickerstaff, Whatley, Ryan & Burkhalter, Inc.; September 11, 2006, page 5.

Summary: The original language is just fine. The unearned premium reserve ratios and loss reserve ratios are company specific, varying significantly from company to company.

Response: The current regulation simply references a "reserves ratio." The proposed regulation distinguishes the unearned premium reserves ratio from the loss reserves ratio. It also recognizes a by-line reserves ratio, rather than a single reserves ratio for each company. As indicated in the responses to similar comments above, the Commissioner has determined that the proposed regulation sufficiently recognizes and reliably projects the reserves ratio for ratemaking purposes.

Commentor Shawna Ackerman, Pinnacle Actuarial Resources, Inc., on behalf of ACIC, PIFC, AIA; September 13, 2006; page 16;
Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 16 - 17

Summary: The proposed regulation makes no sense, is internally inconsistent and lacks clarity. The proposal requires industry-wide reserve calculations by Annual Statement line, while the current regulation allows company-specific calculations, and the calculation is based on historical data. The loss reserves ratio is based on calendar year results, whereas projected losses are based on accident year losses. The loss reserves ratio is influenced by prior year reserve developments that may have little to do with the insurance program being filed. There is no recognition that the specific program may have higher or lower expected reserves than the line as a whole.

Response: Using an industry-wide by-line reserve ratio is consistent with using an industry-wide by-line leverage ratio. The calendar year reserve ratio provides a reasonable approximation for investment income on an accident year or policy year cash flow basis.

Commentor Shawna Ackerman, Pinnacle Actuarial Resources, Inc., on behalf of ACIC, PIFC, AIA; September 13, 2006; page 16 – 17 and Transcript page 34 - 35;
Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 17

Summary: For the unearned premium reserves ratio, a single industry-wide reserves ratio by line can not recognize the expected cash flows of the unearned premium reserve for an individual company and assumes every company offers the same (or actually an average) policy term and payment options by line. This is inconsistent with 2644.13, which requires the company to reflect the additional income it receives from payment plans as a reduction to the rate. Ancillary income is based on company-specific data. Using industry reserve ratios does not reflect the differences in insurer reserving philosophies or expected reserve levels. It is unclear how the combination of a company specific yield with an industry-wide generic reserves ratio can reflect an insurer's investment income. It appears inconsistent with 1861.05, which specifically references an "insurance company's investment income." From an actuarial perspective, there is a conflict. A generic reserves ratio will only coincidentally reflect the insurance company's investment income if it happens to match the reserve levels attributable to the insurance product under review.

Response: Policy terms other than a year are common only on personal automobile policies. The vast majority of personal automobile policies are written for six-month terms. Therefore there is no significant distortion using industry by-line averages for unearned premium reserves. The potential problem of double-counting investment income and ancillary income on uncollected premium is addressed in the yield calculation in section 2644.20(f). Using an industry-wide by-line reserve ratio is consistent with using an industry-wide by-line leverage ratio. The company-specific calculation of yield meets the requirement of 1861.05 relating to the "insurance company's investment income."

Commentor Russina Sgoureva; Progressive West Insurance Company, September 13, 2006; page 10,

Summary: It is inappropriate for the regulations to apply an industry-wide unearned premium reserve ratio while allowing for a loss reserve ratio for each line. This approach is detrimental to insurers with lower than average reserve ratios. Insurers should be allowed to establish reserve ratios based upon actual industry-specific data.

Response: The regulations treat unearned premium reserve ratios and loss reserve ratios the same, in that they are both ratios based on industry averages. Thus there is no inconsistency. Using an industry-wide by-line reserve ratio is consistent with using an industry-wide by-line leverage ratio.

Commentor Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 19,

Summary: The commentor provides general comments on this section and notes that, regardless of the value indicated by the data, the reserves ratio for earthquake is to be 1.00, which may be too high for small insurers that write earthquake coverage.

Response: The Commissioner has determined that an appropriate reserves ratio for the earthquake line is 1.0 regardless of the size of the insurer writing the coverage. This is consistent with the Commissioner's July 14, 2006, decision regarding Safeco's earthquake insurance rates. (In the Matter of the Rate Applications of First National Insurance Company of America, SAFECO Insurance Company of America, and SAFECO Insurance Company of Illinois, File No. PA04041210.) It is an appropriate actuarial and financial standard.

Section 2644.23 Credibility Adjustment

Commentor: William K. Johanneson, on behalf of Farmers Insurance Group, September 13, 2006, page 8.

Summary: It is unclear how the credibility standard of 3,000 claims was derived, as these standards can vary greatly depending on the data and methods used to arrive at the standard. Furthermore, we question the necessity of capping at four the number of years used in calculating the complement of credibility. No standards for insurance ratemaking, actuarial or otherwise, make any recommendation to this end. This language should be removed or modified so that insurers are allowed to develop their own standards and file their rationale.

As with loss trending, the requirement that credibility be applied separately by form for homeowners is unduly restrictive and unnecessary. Indicated rate levels by form can be developed using standard relativity analyses. The language should be revised to apply credibility to the line as a whole.

Response: Three thousand claims is a reasonable standard, based on the variability of the frequency and severity of homeowners and private passenger auto claims. The four-year cap is longer than the two-year cap used by the Insurance Services Office and thus is more generous to the insurers. Applying the credibility standard by form for homeowners was recommended by commentors in the workshops.

Commentor: Foundation for Taxpayer and Consumer Rights; September 13, 2006; Allan I. Schwartz on behalf of The Foundation for Taxpayer and Consumer Rights; September 13, 2006; pages 10-11.

Summary: Proposed subsection (f) references the annual loss and annual premium trend, but does not give a reference to where these items are defined, as is the case for most other portions of the proposed regulation. In order to be consistent, it should be indicated that the annual loss trend and annual premium trend area defined in 2644.7.

Subsection (g) allows for the possibility of an alternate complementary loss and defense and cost containment expense when the credibility weight is less than 25%. However, the regulation does not indicate how this alternate calculation should be performed, other than being actuarially sound and reasonable.

Instead of leaving the alternate credibility calculation completely open ended, the regulation could give one or more possibilities, in order of preference for how to deal with situations of small credibility. Some possible ways to deal with small credibility are as follows:

> Add additional years of experience beyond three years, up to some limit (e.g., 10 years) in order to increase the credibility of the data;
>
> In determining the complementary trend used in calculating the complementary loss DCCE, use where available the change in the projected statewide loss cost from the latest ISO approved filings, at the time the current rates went into effect for the insurer (but no more than four years prior to the date of the current insurer filing) in relation to the ISO loss cost in effect at the date of the current rate filing by the insurer. The trend indicated from the ISO filings can be used either alone or in conjunction with the otherwise calculated complementary trend (e.g., 50% weight given to each). But the method should be made clear in the regulation.
>
> Have some minimum level of credibility assigned to the insurer's own experience (e.g., have the insurer experience be assigned a 25% credibility even if the credibility value otherwise derived from the regulation is less than 25%.

Section 2644.23(g) proposes that if the credibility weight is less than 25%, a modification to the otherwise specified credibility procedure could be allowed. In order to accommodate additional years of experience to increase credibility, the following text should be used for the recorded period: "The recorded period shall be the most recent three years for which reliable data are available, unless the credibility of that experience is less than the value contained in Section 2644.23(g). In that case, additional years shall be added to the recorded period until sufficient years are used to reach the credibility standard set forth in Section 2644.23(g). In no case shall the recorded period exceed ten years, even if the ten years of experience does not have credibility as high as that contained in Section 2644.23(g)."

Response: Changes have been proposed to the "recorded period" in the October 5 version of section 2642.6 to address the commentor's concern expressed above. References to section 2644.7 have been added to subsection (f). The Commissioner has determined that reference in (g) to the fact that the alternative calculation must be sound and actuarially reasonable in the circumstance sufficiently describes what is required yet allows appropriate flexibility to recognize different circumstances. Therefore, this portion of the comment is therefore rejected.

Commentor: Randal Farwell on behalf of Interinsurance Exchange; September 13, 2006, page 8.

Summary: The method proposed to calculate the complement of credibility is only one of many possible approaches. Additional methods should be allowed as well, with the burden of proof falling to the insurer, much like CDI allows for catastrophe models in

§2644.4. Also, CDI should clarify the expectation for other lines of business. Finally, in the proposed formula, just prior to section (d), it appears that there is a missing plus sign between "comp loss" and "DCCE."

Response: The method is sound actuarially. The Department of Insurance has determined over the years of administering the existing regulations that using a single sound methodology is the only way to assure reasonable, timely, consistent review given the number of filings the Department receives. The regulation text and formula are clear and unambiguous as to the meaning of "comp loss and DCCE."

Commentor Michael A. Walters, Towers Perrin, on behalf of the Association of California Insurance Companies; September 13, 2006; page 18.

Summary: No other data bases apparently are allowed to credibility weigh with the insurer's specified experience base. Why must you assume that the last approved rate was adequate. Smaller insurers especially are at a disadvantage if the only option for the complement is the last approved rate.

Response: Please see the response immediately above, which is incorporated herein by this reference. The inherent assumption that rates were adequate when approved is reasonable, given the Commissioner's obligation not to approve rates that are inadequate. Smaller insurers are provided relief in section 2644.23(g)

Commentor Michael A. Walters, Towers Perrin, on behalf of the Association of California Insurance Companies; September 13, 2006; page 18.

Summary: Credibility is not a simple concept lending itself to only a single claim count standard. There is also the credibility of consistency.

Response: The selection follows sound actuarial practices.

Commentor Shawna Ackerman, Pinnacle Actuarial Resources, Inc., on behalf of ACIC, PIFC, AIA; September 13, 2006; page 17;
Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 17 - 18

Summary: The regulation proposes a formula for calculating the complement of credibility. A four-year cap is placed on the trend period, potentially penalizing an insurer who has not made a rate change for more than four years. This lacks authority and clarity. However, if the selection of the annual net trend between the date of the current rate and the effective date of the proposed rate is appropriate, then a cap on that period is not appropriate. The cap on the trend period should be eliminated. This subsection creates an incentive to file more frequently. There is no authority or justifiable support for this provision. The assumption inherent in the proposed complement formula is that the current rate level, adjusted for trend, is presumed adequate. This assumption could be invalid. However, the proposed regulation should

be modified to permit other reasonable measures consistent with sound actuarial practices. These could include the experience of other carriers or a rating bureau, a longer period of data, countrywide data or recognition of prior rate inadequacy/redundancies as developed in a previous rate review.

Response: Please see responses to comments set forth above and incorporated herein by this reference. The inherent assumption that rates were adequate when approved is reasonable, given the Commissioner's obligation not to approve rates that are inadequate.

Commentor Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 19 – 20.

Summary: The proposed regulations do not indicate whether the standard for full credibility for homeowners and personal auto is determined on a per occurrence or per person basis. The regulations are silent on credibility standards for other lines and should be amended to specify that an actuarially sound credibility standard can be used.

A single credibility method is specified but it is unclear whether this methodology is to be applied in auto and homeowners filings, or in all filings.

The 25% threshold for use of an actuarially sound complementary data source is too low; it should be 75%.

When the credibility weight is less than 75%, the credibility methodology needs to use an external source of data for the 25-100% complement, whether it is company specific data from other states, industry-average data from California or another actuarially sound source of complementary data.

Response: Different companies count claims in different ways. The regulations do not specify a single counting method because of these differences. The regulations are clear that the credibility method is to be applied to all commodity lines. The 25% threshold strikes a reasonable balance between relieving the Department's administrative burden and providing relief to the smaller insurers.

Section 2644.24 Trended Current Rate Level Earned Premium

Commentor Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 20.

Summary: The methodology set forth is appropriate.

Response: A specific response is not required.

Section 2644.25 Reinsurance

Commentor: William K. Johanneson, on behalf of Farmers Insurance Group, September 13, 2006, page 8.

Summary: This section should be modified to allow the costs of all types of reinsurance that comply with Statutory Accounting Principles, including treaty reinsurance, to be included when making rates in all lines of business. The language as written is a direct contradiction of actuarial ratemaking principles that require ratemaking to consider all costs associated with the transfer of risk. Reinsurance is a real cost of doing business in a state with a significant catastrophe potential, like California. The proposed language would discourage companies from purchasing reinsurance, which would have the practical effect of deterring these companies from writing higher risk business, such as brush fire exposures.

The additional requirement proscribing an allowance for reinsurance through unauthorized reinsurers is unduly restrictive. Insurers are already penalized for unauthorized reinsurance through the Schedule F penalty. The restriction should be modified to allow for the cost of unauthorized reinsurance if collateralized, or eliminate the restriction altogether.

Reinsurance agreements are proprietary documents. Public disclosure of specific terms and conditions of these agreements as part of a rate filing serve no public purpose. Where a regulator deems it necessary to review the documents as part of a rate filing, provisions to protect their confidentiality should be in place.

Response: The Commissioner has determined that he will allow inclusion of reinsurance for the specified coverages only at this time, based, in part, on the rationale set forth in the July 14, 2006, decision involving Safeco's earthquake insurance rates. (In the Matter of the Rate Applications of First National Insurance Company of America, SAFECO Insurance Company of America, and SAFECO Insurance Company of Illinois, File No. PA04041210.). The reinsurer must be admitted because the Commissioner has little authority over non-admitted reinsurers. The Commissioner agrees that proprietary documents should remain confidential.

Commentor: Pamela Pressley, on behalf of the Foundation for Taxpayer and Consumer Rights (FTCR); September 13, 2006, pages 1-4; Oral statement of Pamela Pressley, September 13, 2006, page 43,

Allan I. Schwartz on behalf of The Foundation for Taxpayer and Consumer Rights; September 13, 2006; pages 11-12; Oral statement of Allan Schwartz, September 13, 2006, Transcript pages 50-52.

Alexis K. Wodtke, on behalf of Consumer Federation of California (CFC); September 13, 2006; Page 2.

Summary: The proposed regulation text allows, subject to certain conditions, for reinsurance costs to be reflected in the ratemaking formula for earthquake and medical malpractice reinsurance with attachment points over one million dollars. CDI should not allow this. The Commissioner previously considered the issue of reinsurance when the

original ratemaking regulations were adopted, and he properly rejected the inclusion of unregulated reinsurance costs in the ratemaking formula.

In the rulemaking proceeding that formed the basis of the current rate regulations, insurance companies requested that ratemaking be performed on a net basis after reinsurance. The Commissioner considered, and then rejected that suggestion, finding instead that ratemaking should be done on a direct basis before reinsurance.

The proposed text opens a regulatory hole (because reinsurance rates are exempt from regulation under California Insurance Code Section 1851) and leaves insurers free to add a wholly unregulated reinsurance costs to the price the consumer pays, undermining the whole regulatory program. Allowing insurers to calculate earthquake insurance on a net basis could result in insurers proposing increases in the magnitude of +40% or more.

Because of the methodologies used by insurers to allocate their nationwide reinsurance costs to California, it is difficult, if not impossible, to determine whether those allocations are accurate given that they often rely on projected losses based on computer models for other lines and in other states that may not be subject to review in a California proceeding.

Without waiving arguments in opposition, proposed subsection (c) indicates that adjustments should be made to the numerator and denominator of the loss reserve ratio and unearned premium reserve ration when considering reinsurance; however the specific adjustment contemplated is not given. Is the adjustment the CDI plans to use net data, as opposed to direct data, to calculate the values? If not, what specific adjustments are being requested?

Response: The Commissioner disagrees with the commentor's characterization of the original rulemaking file as it relates to prior approval, for the reasons described in the July 14, 2006, decision involving Safeco's earthquake insurance rates. (In the Matter of the Rate Applications of First National Insurance Company of America, SAFECO Insurance Company of America, and SAFECO Insurance Company of Illinois, File No. PA04041210.) Furthermore, the Commissioner is always free to revise regulations once they have been adopted, and as set forth in the Safeco decision, he has determined that the regulations should specifically recognize reinsurance for earthquake and medical malpractice. The regulations require the Commissioner to consider various factors in connection with the reinsurance transaction, including but not limited to whether the transaction was entered into in good faith in an arms-length transaction and at fair market value for the coverage provided. The fact that it may be difficult to calculate the appropriate values to include is an insufficient reason to prevent consideration of reinsurance altogether. The Commissioner rejects the comment regarding subsection (c) since he has determined that this language is sufficiently clear.

Commentor: Pamela Pressley, on behalf of the Foundation for Taxpayer and Consumer Rights (FTCR); September 13, 2006, pages 1-4; Oral statement of Pamela Pressley, September 13, 2006, page 43,

Allan I. Schwartz on behalf of The Foundation for Taxpayer and Consumer Rights; September 13, 2006; pages 11-12; Oral statement of Allan Schwartz, September 13, 2006, Transcript pages 50-52.

Alexis K. Wodtke, on behalf of Consumer Federation of California (CFC); September 13, 2006; Page 2.

Summary: There is no viable way for the Department and intervenors to determine whether a particular insurer's unregulated reinsurance premiums and expenses are reasonable. For example, short of discovery and cross-examination in a contested rate proceeding, how are the Department and intervenors to determine whether the reinsurance premiums that insurers pay on a nationwide basis are accurately allocated to California earthquake lines for inclusion in their rate filings? This task is rendered virtually impossible when those allocations are determined on the basis of the proportion of California earthquake insurance projected losses to projected losses for other states and other lines, including by the use of computerized loss models in other states. Those non-California projected losses and the computerized loss models from which they are derived are not subject to review by the Department or intervenors in California earthquake insurance rate proceedings.

Requiring a hearing only when the reinsurance costs exceed a 30% threshold, especially when there are no objective standards in place to determine the reasonableness of the insurer's reinsurance costs is inadequate. The best approach is to not set this dangerous precedent.

Response: The Commissioner disagrees with this comment. Because the applicant has the burden of proof, the Department and any intervenors will be able to scrutinize the information provided to satisfy that burden, as they currently do for any other rate application. If the requested rate change exceeds 7% or 15%, a hearing will be required upon request. This regulation further provides for a hearing regarding the reasonableness of the reinsurance costs in certain circumstances, thus allowing a further opportunity for interested members of the public to test whether the costs and reasonable and should be included in the rates. The Commissioner rejects this comment.

Commentor: Pamela Pressley, on behalf of the Foundation for Taxpayer and Consumer Rights (FTCR); September 13, 2006, pages 1-4; Oral statement of Pamela Pressley, September 13, 2006, page 43,

Allan I. Schwartz on behalf of The Foundation for Taxpayer and Consumer Rights; September 13, 2006; pages 11-12; Oral statement of Allan Schwartz, September 13, 2006, Transcript pages 50-52.

Alexis K. Wodtke, on behalf of Consumer Federation of California (CFC); September 13, 2006; Page 2.

Summary: The Department has provided no justification in the statement of necessity or otherwise as to why it has decided to open up this regulatory hole for earthquake and medical malpractice lines.

Response: The Commissioner disagrees that this is a regulatory hole. The rationale was set forth in the Commissioner's decision involving the Safeco earthquake rate application, in which FTCR was an intervenor and Mr. Schwartz was a witness on behalf of FTCR. (In the Matter of the Rate Applications of First National Insurance Company of America, SAFECO Insurance Company of America, and SAFECO Insurance Company of Illinois, File No. PA04041210.)

Commentor: Pamela Pressley, on behalf of the Foundation for Taxpayer and Consumer Rights (FTCR); September 13, 2006, pages 1-4; Oral statement of Pamela Pressley, September 13, 2006, page 43,

Allan I. Schwartz on behalf of The Foundation for Taxpayer and Consumer Rights; September 13, 2006; pages 11-12; Oral statement of Allan Schwartz, September 13, 2006, Transcript pages 50-52.

Alexis K. Wodtke, on behalf of Consumer Federation of California (CFC); September 13, 2006; Page 2.

Summary: The Department should consider having a transition program, where each year only X percent of the rate level change could be due to the rate cost, perhaps 10 percent a year of a rate change caused by reinsurance, so that way policyholders don't have a shock all of a sudden in terms of the premium being charged them.

Response: The Commissioner disagrees that the change to this regulation will inevitably lead to premiums which are a shock to consumers. Insurers are entitled to rates which are not inadequate and fall within the range of reasonableness. A transition program is unnecessary. Insurers are, of course, free to request less than the indicated rate change, and frequently do so.

Commentor: Randal Farwell on behalf of Interinsurance Exchange; September 13, 2006, pages 2, 8.

Summary: Subsection (a) would exclude the "costs and benefits" of reinsurance from the ratemaking process for all lines of business except earthquake. This restriction is inconsistent with the ratemaking principles of the Casualty Actuarial Society (CAS), which specify that consideration shall be given to all costs associated with an insurance transaction. For lines of insurance such as homeowners, reinsurance is an important and prudent consideration for primary insurers. Disallowing this ordinary and reasonable business expense for an insurer will lead to inadequate and unrealistic rates. It could also threaten an insurer's solvency by tempting it to not purchase sufficient reinsurance.

CDI should review the CAS ratemaking principles for guidance. The proposal should be modified to allow carriers to include the anticipated costs and benefits of reinsurance, so long as it is an appropriate and prudent expenditure.

Response: The Department is quite familiar with the CAS ratemaking principles and takea exception to any implication that it is not. However, at this time the Commissioner

has determined that he will allow consideration of reinsurance for earthquake and medical malpractice only, for the reasons set forth in this rulemaking file.

Commentor Richard J. Roth, Jr., Bickerstaff, Whatley, Ryan & Burkhalter, Inc.; September 11, 2006, page 5

Summary: No insurance department regulates reinsurance rates.

Response: The Department generally agrees that reinsurance rates are not regulated in the same way insurance rates are. Consequently, while the proposed regulations allow for the costs of reinsurance for earthquake and specified medical malpractice coverages, the Department maintains that expanding use of net ratemaking beyond these two coverages is not appropriate for, among other things, the reason Mr. Roth notes.

Commentor Richard J. Roth, Jr., Bickerstaff, Whatley, Ryan & Burkhalter, Inc.; September 11, 2006, page 5

Summary: Facultative reinsurance is reinsurance on a specific risk. It is impossible to prior approve such rates.

Response: The proposed regulations would not impose a prior approval requirement on medical malpractice facultative reinsurance, but instead would simply allow those costs to be considered in the ratemaking process, subject to certain conditions set forth in the regulation.

Commentor Richard J. Roth, Jr., Bickerstaff, Whatley, Ryan & Burkhalter, Inc.; September 11, 2006, page 5

Summary: The reinsurance rates for both earthquake and medical malpractice are based on exceedance probability curves, not the considerations set forth in subsection (b).

Response: The proposed regulation does not purport to set the rates which insurers will pay for these reinsurance costs. Instead, the proposed regulations are designed to determine what, if any, amount shall be reflected in the proposed rates charged to consumers.

Commentor Richard J. Roth, Jr., Bickerstaff, Whatley, Ryan & Burkhalter, Inc.; September 11, 2006, page 5 -- 6

Summary: Subsections (d) through (g) are not the responsibility of the Rate Regulation Division, but of the Financial Analysis Division. The Rate Regulation Division does not have the expertise to enforce (d), which belongs to the financial examiners in FAD.

Response: The Financial Analysis Division does not review rate applications. That is one of the functions of the Rate Regulation Division. The Financial Analysis Division

does not determine what, if any, reinsurance costs shall be included in the rates charged to consumers. It is the prerogative of the Commissioner to allocate the functions performed by the Department among the various branches, divisions, bureaus, and employees of the Department.

Commentor Richard J. Roth, Jr., Bickerstaff, Whatley, Ryan & Burkhalter, Inc.; September 11, 2006, page 6.

Summary: The drafters of the regulations do not understand reinsurance. Most reinsurance is ceded to affiliates, called pooling. The pool cedes to outside reinsurers. For earthquake, it is common to cede to unauthorized reinsurers outside of the United States. Facultative medical malpractice reinsurance is uncommon, except possibly for large clinics, but they are essentially self-insured. Hospital malpractice might have some facultative reinsurance, but it is essentially self insurance.

Response: The purpose of the proposed regulation is to determine, what, if any, of the costs of the specified reinsurance shall be allowed for ratemaking purposes. The comments are irrelevant for that purpose. The Commissioner rejects the comment, and the assertion that the drafters of the regulations do not understand reinsurance.

Commentor Richard J. Roth, Jr., Bickerstaff, Whatley, Ryan & Burkhalter, Inc.; September 11, 2006, page 6

Summary: The requirement is subsections (i) and (j) that the Commissioner shall hold a hearing is particularly egregious because the Department is the consumer's representative. When did the "consumer representatives" take over the Department? They don't even have to file a conflict of interest disclosure statement, and there is no oversight as to the fees they charge.

Response: California Insurance Code Sections 1861.05 and 1861.10 authorize consumer representation in hearings such as these. Issues related to the fees associated with the hearings, and conflict of interest disclosure statements, are beyond the scope of the proposed regulation, and therefore a response is not required. However, the Department notes that detailed regulations govern intervenor representation and compensation, and the Department rejects the allegation that there is no oversight as to fees charged.

Commentor Richard J. Roth, Jr., Bickerstaff, Whatley, Ryan & Burkhalter, Inc.; September 11, 2006, page 6

Summary: How can a hearing determine the reasonableness of reinsurance rates? Those rates even vary from year to year with the number of hurricanes.

Response: The Department recognizes that reinsurance costs will vary over time. Whether the reinsurance transaction represents fair market value for the coverage provided will be determined as set forth by these regulations and based upon the

information provided in connection with a particular rate application. Mr. Roth apparently does not understand the regulations. They do not address the cost of reinsurance associated with hurricanes in California.

Commentor Richard J. Roth, Jr., Bickerstaff, Whatley, Ryan & Burkhalter, Inc.; September 11, 2006, page 6

Summary: What pressing regulatory need is being addressed with this section? This section would eliminate any competition with the California Earthquake Authority. Is this the intent?

Response: This section is designed to allow for consideration of reinsurance costs for ratemaking purposes in some circumstances, as set forth in the regulation. The intent is not to eliminate competition with the California Earthquake Authority, which is subject to a different regulatory system. Although the commentor alleges that this section would eliminate any competition with the California Earthquake Authority, the commentor does not elaborate on the basis for this statement, making a detailed response impossible. The Department disagrees that this section eliminates competition with the California Earthquake Authority. In fact, the Department believes that this section is designed to recognize costs associated with offering earthquake insurance outside of the California Earthquake Authority.

Commentor Shawna Ackerman, Pinnacle Actuarial Resources, Inc., on behalf of ACIC, PIFC, AIA; September 13, 2006; page 17;
Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 18

Summary: Actuarial ratemaking principles specify that consideration should be given to all costs associated with the insurance transaction. This includes reinsurance. Subsection (a) should be deleted. This provision lacks authority and consistency.

Response: For the reasons set forth in this rulemaking file, the Commissioner has determined that the only reinsurance costs which he will consider for inclusion in ratemaking at this time are the two specified in section 2644.25(b). As has been noted by FTCR in its comments, reinsurance costs are not subject to the prior approval provisions of Proposition 103. The comment is rejected.

Commentor Shawna Ackerman, Pinnacle Actuarial Resources, Inc., on behalf of ACIC, PIFC, AIA; September 13, 2006; page 18;
Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 18

Summary: The proposed regulation recognizes reinsurance costs for earthquake and medical malpractice facultative reinsurance with attachment points above $1 million. Any insurance line or program using reinsurance should have an opportunity to reflect those costs. At a minimum, treaty excess of loss reinsurance should be added. Allowing

the costs associated with obtaining the necessary reinsurance will encourage insurers to offer the higher limits and increase consumer choice. The absence of regulation of reinsurance rates does not differentiate that cost from any of the other costs of providing the insurance. Employee wages are not regulated, the price for facilities is not regulated, prices for paper, pencils, and computers are not regulated. Reinsurance must be purchased to provide the insurance, and the cost of obtaining it should be included in the rates. Excluding it may result in inadequate rates.

Response: To the extent the comment suggests that reinsurance costs should be allowed for other lines, please see the response to the similar comment above.

Commentor Shawna Ackerman, Pinnacle Actuarial Resources, Inc., on behalf of ACIC, PIFC, AIA; September 13, 2006; page 18;
Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 18

Summary: Subsection (c) recognizes that insurance premiums are subject to specific payment plans and impacts the expected investment income available to the insurer. However, 2644.12 fails to make the same consideration by using an industry-wide average for all insurers.

Response: The Commissioner has determined that it is inappropriate to adjust the efficiency standard calculations to reflect the reinsurance costs reflected in section 2644.25.

Commentor Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 20

Summary: Reinsurance costs are real and should be included in individual company filings. The exclusion of reinsurance costs is prejudicial to smaller insurers and creates an unlevel playing field between large and small insurers.

Response: Please see response to similar comments above.

Section 2644.26 Reinsurance Recoverables

Commentor: Pamela Pressley, on behalf of the Foundation for Taxpayer and Consumer Rights (FTCR); September 13, 2006, page 1 - 2

Summary: The commentor indicates it is commenting on section 2644.26, but its comments do not specifically reflect or otherwise mention the provisions of section 2644.26.

Response: To the extent the commentor generally objects to allowing consideration of the specified reinsurance costs, the Commissioner incorporates herein by this reference his responses to the comments set forth under section 2644.25 above.

Commentor Richard J. Roth, Jr., Bickerstaff, Whatley, Ryan & Burkhalter, Inc.; September 11, 2006, page 6.

Summary: This section should be deleted. It appears innocent, but is not. It is difficult for actuaries to estimate IBNR amounts on a reinsurance contract. In a hearing, this issue could turn the hearing into a farce. If it is covered by reinsurance, why does it matter? The only thing that matters is the Annual Statement Schedule P, Part 2.

Response: Section 2644.25 references reinsurance recoverables. Therefore, a definition of that term clarifies the meaning of the regulations. This is a standard actuarial definition. The commentor does not indicate why he believes it is difficult for actuaries to estimate IBNR amounts on a reinsurance contract. However, even if it is difficult to estimate, IBNR is typically and appropriately included. It is also unclear why the commentor believes a hearing will become a farce. However, the Department believes that the administrative law judge will not allow that to be the case.

Commentor Shawna Ackerman, Pinnacle Actuarial Resources, Inc., on behalf of ACIC, PIFC, AIA; September 13, 2006; page 18 – 19;
Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 19.

Summary: This definition appropriately includes loss adjustment expense since many reinsurance agreements do contain provisions for the recovery of loss adjustment expenses. CDI treats loss adjustment expenses differently depending on whether it is defense and cost containment expense or adjusting and other expense. The full amount of company specific DCCE is allowed in the rate formulation, whereas A&OE is capped along with other expenses via the efficiency standards. The full reflection of the loss adjustment expense in the recoverables creates a potential mismatch. The expense component will contain a capped expense allowance for A&OE. The recoverables, which are subtracted from the formula, will contain uncapped A&OE. This provision lacks clarity, consistency and authority.

Response: The Commissioner has determined that this does not create a mismatch. The definition of reinsurance recoverables only applies to the section 2644.25 calculation.

Commentor Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 20.

Summary: There are no specific problems with this section.

Response: A specific response is not required.

Section 2644.27 Variance Request

The *20th Century* Court emphasized the importance of variances and stated time and time again that the variances expressly provided for in the regulations are the final mechanism for rate adjustments necessary to avoid confiscation before the final rate determination is made. The Commissioner recognizes the importance of variances and is fully cognizant that the Court in *20th Century* relied on variances as an extremely important protection against confiscation. Both the *Calfarm* and *20th Century* Courts made it clear that the Commissioner has the legal authority to take those steps reasonably necessary to make the job of rate regulation manageable. (*20th Century, (*quoting *Calfarm)* , 8 Cal. 4th 216, 245; 32 Cal. Rptr. 807, 824.) The Commissioner is also aware that insurers must be allowed an opportunity to earn a fair and reasonable rate of return. Variances are important as the constitutional safety valves. However, a variance cannot be created for every possible contingency. The Commissioner has determined that variances must be carefully considered, otherwise the exceptions will swallow the rule making meaningful rate regulation impossible. And the opposite is also true. The regulations must contain enough of these safety valves to ensure insurers may avoid confiscation.

Commentor Mary B. Gaillard, on behalf of AIG, September 12, 2006, page 5 – 6.

Summary: A variance should be added for "demonstrated changes in the company distribution systems."

Response: Section 2644.12(b) provides that efficiency standard shall be set separately for each insurance line, and separately for insurers distributing through independent agents and brokers, through exclusive agents, and through employees of the insurer selling insurance on a direct basis. The October 5 version of the regulations adds language indicating that for an insure using more than one distribution system, the efficiency standard shall consist of an average weighted by earned premium for each distribution system. This new language should address the concerns expressed in the comment.

Commentor Mary B. Gaillard, on behalf of AIG, September 12, 2006, pages 5-6.

Summary: A variance should be added where "the insurer employs the same methodology in setting rate levels as when calculating its reserves, and the methodology in Section 2644.6 would, if utilized, yield substantial differences to the financial statements.

Response: This comment is rejected for the reasons set forth in connection with similar comments made by the commentor regarding section 2644.6 above.

Commentor Mary B. Gaillard, on behalf of AIG, September 12, 2006, pages 5-6.

Summary: A variance should be added where there is "rapid growth or reduction in a book of business."

Response: The situation as described in the comment would likely be addressed by

the variance set forth in section 2644.27(f)(1). To the extent it is not, where there is a sudden and rapid growth or reduction in a book of business the insurer is free to make a rate filing in order to compensate for any changes and the commentor does not indicate why a rate application cannot account for such changes. For these reasons, because the ratemaking formula would account for this fact, and because variance cannot be created for every contingency, the comment is rejected.

Commentor Mary B. Gaillard, on behalf of AIG, September 12, 2006, pages 5-6; oral statement of Mary Gaillard, AIG, transcript pages 40-41.

Summary: A variance should be added where there is "the presence of several large losses, which would cause the link ratios to be too volatile."

Response: The regulatory formula adequately addresses this situation. The comment is rejected.

Commentor Mary B. Gaillard, on behalf of AIG, September 12, 2006, pages 5-6.

Summary: A variance should be added where there are "are apparent trends in the link ratios that may require judgmental selections."

Response: The regulatory formula adequately addresses this situation. The comment is rejected.

Commentor Mary B. Gaillard, on behalf of AIG, September 12, 2006, pages 5-6.

Summary: A variance should be added where it "can be demonstrated that other external factors not reflected in the historical data can support the use of an alternative formula or experience period."

Response: This comment is rejected. The variance described is so vague it could be invoked under almost any circumstance. This would have the practical effect of eviscerating the regulations. To the extent the comment is applicable to specialty lines, further changes have been proposed regarding specialty lines which should address the comment. Changes proposed to sections 2644.27(f)(9) and (10) should also address the concerns expressed in this comment.

Commentor Mary B. Gaillard, on behalf of AIG, September 12, 2006, pages 5-6.

Summary: A variance should be added where the industry leverage factor and surplus in section 2644.17 is inappropriate for an individual insurance carrier or line of business.

Response: This comment is rejected. The variance described is so vague it could be invoked under almost any circumstance. This would have the practical effect of eviscerating the regulations. The ratemaking formula and existing variances adequately address the concerns expressed.

Commentor Mary B. Gaillard, on behalf of AIG, September 12, 2006, pages 5-6.

Summary: A variance should be added where the industry reserve ratio in Section 2644.21 is inappropriate for an individual insurance carrier or line of business.

Response: This comment is rejected. The variance described is so vague it could be invoked under almost any circumstance. This would have the practical effect of eviscerating the regulations. The ratemaking formula and existing variances adequately address the concerns expressed.

Commentor Alexis K. Wodtke on behalf of Consumer Federation of California; September 13, 2006; Page 2.

Summary: Only those variances which could not have been anticipated when a rate application is filed, and which materially distort record period results, should be permitted to be filed after the rate application.

Response: The Commissioner has determined to reject this comment. In connection with the Department's review of rate applications, an applicant will often amend various aspects of its application in response to issues raised during the course of review. (Amendments cannot increase the requested rate change.) The Commissioner believes that there is no reason an applicant should necessarily withdraw and refile a rate application in all circumstances in order to request a variance. Requiring public notice of the variance, whether filed with the application or later, will provide sufficient notice to the public of the filing of the variance request. Having said that, the Commissioner recognizes that there may be situations where a variance request changes the application to such an extent that a new application is appropriate. However, those circumstances are best address in the course of review of a specific rate application.

Commentor Alexis K. Wodtke on behalf of Consumer Federation of California; September 13, 2006; Page 2

Summary: The proposed rule allowing an insurer to request a variance "after the filing of the rate application" and without a hearing may create a situation in which rate cases may become interminable, a situation that neither the Department nor intervenors are equipped to handle. Also, the procedure for considering late-filed variances may inadequately protect consumers' interest in obtaining a fair hearing before the Commissioner.

Response: The comment is rejected. Because public notice is provided of the filing of a variance request, whether requested at the time of the filing of the rate application or afterwards, the Commissioner is unaware of the manner in which consumers' interest in obtaining a fair hearing would be inadequately protected. Existing timeline provisions ensure that review or rate applications do not become interminable. Additionally, in the cases of rate applications which are the subject of a public hearing, the administrative law

judge is charged with controlling the course of the hearing. The timing of the filing of a variance request does not impact the review of an application.

Commentor Alexis K. Wodtke on behalf of Consumer Federation of California; September 13, 2006; Page 2.

Summary: Matching costs in a representative test period is a very significant part of ratemaking. In ratemaking the test-period is like a snap-shot in time. The test-period results are adjusted to allow for the effect of various known or reasonable anticipated changes in gross revenues, expenses and other conditions. Allowing insurers to make a variance request after the filing of a rate application will lead to inaccurate results. Variance requests should not be allowed after a rate filing is made without a showing of an extraordinary event that materially impacts the record period. Insurer should not be allowed to interrupt rate hearing by making variance requests.

Response: The comment is rejected for the reasons set forth above. Because of the nature of the hearing process, including the use of prefiled testimony, among other reasons, the Commissioner has determined that this provision is unlikely to result in the interruption of rate hearings by insurers seeking to submit variance requests during the course of a hearing. The overwhelming majority of rate filings never reach the formal, administrative hearing stage.

Commentor: William K. Johanneson; Farmers Insurance Group; September 13, 2006; Pages 1, 8-9.

Summary: The variance, which explicitly states what reasons are valid basis for requesting a variance, is far too restrictive. A variance should be added that allows for a variance for "Any other reasons that the insurer can demonstrate to be worthy of a variance."

Response: The comment is rejected. A catch-all variance as suggested would not be sufficiently specific to notify affected persons as to the standards applicable and when such a variance would be approved or rejected. Nor does it provide sufficient guidance to the Commissioner. However, it must be noted that the variance requested is effectively included in section 2644.27(f)(11), which allows a variance when the maximum permitted earned premium would be confiscatory as applied.

Commentor: William K. Johanneson; Farmers Insurance Group; September 13, 2006; Page 1, 8-9.

Summary: A variance should be added to allow trends over a period shorter than 10 years where "it can be shown that trends calculated over other time-periods are more reliable prospectively."

Response: Section 2644.7 adequately addresses the issues raised by this comment. The comment is rejected. The limit to periods of at least 10 years is necessary to reduce

the Department of Insurance's administrative burden. In the absence of such a limit, the Department has found that the multitude of options of selecting four quarters or six quarters on up to 24 or more quarters provides almost endless opportunities for targeting or backing into specific desired outcomes and disputes among the various parties over those outcomes.

Commentor: Pamela Pressley on behalf of Foundation for Taxpayer and Consumer Rights; September 13, 2006; Pages 4-5; Oral statement by Pamela Pressley, September 13, 2006, transcript pages 42-43, 49-50;
Allan I. Schwartz on behalf of The Foundation for Taxpayer and Consumer Rights; September 13, 2006; pages 12-13.

Summary: Allowing additional variances will result in more variance requests by insurers seeking higher rate hikes than would be allowed under the ratemaking formula, and thus lead to more contested issues in rate proceedings.

Response: While there may be some confusion generated by the fact that old section 2646.4 is now proposed section 2644.27 the variances are, for the most part, the same as the existing variances. Additional variances have been added for loss development and trend. At the same time, in sections 2644.6 and 2644.7, the proposed regulations have prescribed very specific particular methods to be used. The Commissioner recognizes that these specific methods may not work in every single circumstances and thus the additional variances are necessary. The Commissioner rejects as speculative the comment that there will necessarily be additional variance requests by insurers seeking higher rate hikes.

Commentor: Allan I. Schwartz on behalf of The Foundation for Taxpayer and Consumer Rights; September 13, 2006; pages 12-13;
Oral statement of Pamela Pressley, on behalf of FTCR, transcript pages 42-43.

Summary: Allowing variances for development and trend will undermine the efficacy of §§ 2644.6 and 2644.7. These will lead to more disputed issues between the filer, CDI and intervenors, with the insurers seeking variances from the ratemaking formula more often in order to seek higher rate increases than the regulations would allow.

Response: In drafting these regulations the Commissioner carefully weighted the risk to consumers and the increased litigation risk associated with variances against including these important safety-valves. However, the loss development and trend variances were added after considering public comment. There is an existing loss trend variance. Mindful of the emphasis the Court placed on variances in *20th Century* decision, the Commissioner has determined that the variances as they appear in the proposed regulations represent an equitable balance as relates to the various competing interests.

Commentor: Allan I. Schwartz on behalf of The Foundation for Taxpayer and Consumer Rights; September 13, 2006; pages 12-13;

Oral statement of Pamela Pressley, on behalf of FTCR, transcript pages 42-43.

Summary: It can be expected that insurers will rely on the regulation methods when those methods give a higher indicated rate level, but will request variances for the use of other methods when that will result in a higher rate level, leading to rates that are biased high and excessive.

Response: The comment is rejected. The Department carefully scrutinizes all rate applications to ensure that they do not result in excessive rates.

Commentor: Allan I. Schwartz on behalf of The Foundation for Taxpayer and Consumer Rights; September 13, 2006; pages 12-13;
Oral statement of Pamela Pressley, on behalf of FTCR, transcript pages 42-43.

Summary: If insurer can use development and trend methods different than that contained in the regulations, then in order to be fair to consumers, all of the parties to the rate filing must be allowed to propose the use of development and trend methods that differ from those contained in the regulations.

Response: Variances are requested by rate applicants, not intervenors.

Commentor: Allan I. Schwartz on behalf of The Foundation for Taxpayer and Consumer Rights; September 13, 2006; pages 12-13;
Oral statement of Pamela Pressley, on behalf of FTCR, transcript pages 42-43.

Summary: Subsection 2644.7(b) contains a requirement that insurers seeking a variance must, "set forth the expected result or impact that the granting of the variance will have as compared to the expected result if the variance is denied." If "expected result or impact" is intended to mean "the indicated rate level," the regulation should state that, explicitly.

Response: The original comment contains a typo. The reference should be to "subsection § 2644.27(b)." Subsection 2644.27(b)(iii) has been amended in the October 5 version of these regulations.

Commentor: Allan I. Schwartz on behalf of The Foundation for Taxpayer and Consumer Rights; September 13, 2006; pages 12-13;
Oral statement of Pamela Pressley, on behalf of FTCR, transcript pages 42-43.

Summary: Subsection 2644.27(b) contains a requirement that insurers seeking a variance must, "identify the facts and their source justifying the variance request and provide the documentation supporting the amount of the change in the applicable

efficiency standard or rate of return." Since the regulations allow for variances related to loss development and trend the sentence should read: "identify the facts and their source justifying the variance request and provide the documentation supporting the amount of the change in the applicable efficiency standard, rate of return, loss development and trend."

Response: This provision of the regulation has been amended in the October 5, 2006, version.

Commentor: Randal Farwell on behalf of Interinsurance Exchange; September 13, 2006, pages 3, 8.

Summary: The variance request process is too rigid. This could cause a backlog of hearing requests. The variances should be incorporated into the applicable sections and hearings relating to variances should be eliminated.

Response: With the exception of the "constitutional variance," a hearing pursuant to a variance request is only required in limited circumstances. There is no reason to believe the regulations will result in a backlog of hearing requests. Under the existing regulations, a hearing was required for all variance requests. That is no longer the case. The Commissioner sees no practical purpose served by incorporating the variances into the applicable sections, which would represent a change from the existing regulation structure. It is easier to determine what variances may be available if they are contained in a separate variance section. The comments are rejected.

Commentor: Randal Farwell on behalf of Interinsurance Exchange; September 13, 2006, pages 3, 8.

Summary: Most, if not all, variances will be actuarial matters that are best resolved via discussions between company and Department staff members. We suggest that duplicate calculations be shown in the rate filing. This would show the difference in the results between using the values specified by the regulation versus the values based on the applicant's actuarial assessment. The current intervention process could then be used if a member of the public felt that granting the variance was not appropriate.

Response: It is contemplated that that is how the variances will generally operate.

Commentor Michael A. Walters, Towers Perrin, on behalf of the Association of California Insurance Companies; September 13, 2006; page 19.

Summary: The variances are too narrow, and there is no catchall variance. It appears the intent was to severely limit the number of variance requests. With all the restrictions listed, few insurers will be able to document a future change in mix of business with evidence of precise change in business operations. The number of areas to be able to justify additional expense costs are too limited.

Response: Please see response to similar comments elsewhere in this rulemaking file. Most of the variances set forth in the proposed regulations are the same as those set forth in the existing regulations. Additional variances are proposed.

Commentor Michael A. Walters, Towers Perrin, on behalf of the Association of California Insurance Companies; September 13, 2006; page 20.

Summary: Only financial insolvency could be used to justify an increase to the maximum permitted premium. What about earning an adequate return for an insurer not in financial trouble?

Response: The regulations are designed to ensure that an insurer is able to earn a fair rate of return without the need for application of a variance.

Commentor Michael A. Walters, Towers Perrin, on behalf of the Association of California Insurance Companies; September 13, 2006; page 20.

Summary: The reasons for trend exception and options for other reasonable methods are too narrow.

Response: The Commissioner rejects this comment. This language was added in response to public comments.

Commentor Michael A. Walters, Towers Perrin, on behalf of the Association of California Insurance Companies; September 13, 2006; page 20

Summary: It is better to allow more reasonable procedures in the basic rate calculation, instead of having to apply as an exception. If there are major problems with the basic rate calculation, it makes little sense to quantify the end result as a plausible rate indication because the answer is meaningless.

Response: In response to comments during the workshop process and in connection with the September public hearing on these regulations, several changes were made to the formula set forth in the proposed regulations to address concerns regarding the reasonableness of the basic rate calculation. The new treatment accorded to specialty lines is but one example. The Commissioner agrees that the basic ratemaking formula should be reasonable and has determined that the formula set forth in the proposed regulations is reasonable and produces reasonable results. Nevertheless, there are some circumstances where a variance may be appropriate, and the proposed regulations correctly recognize that fact. The Commissioner has determined that the regulations do not produce a meaningless result.

Commentor Richard J. Roth, Jr., Bickerstaff, Whatley, Ryan & Burkhalter, Inc.; September 11, 2006, page 6

Summary: In subsection (d), delete the written findings language. The Commissioner is the public's consumer representative and does not have to report to any individual consumer.

Response: The Commissioner believes that, as set forth in California Insurance Code Section 1861.05(c), he should clearly indicate the reasons why he has determined not to grant a hearing when one was requested.

Commentor Richard J. Roth, Jr., Bickerstaff, Whatley, Ryan & Burkhalter, Inc.; September 11, 2006, page 7

Summary: As drafted, variance requests would become common and the Department may be abrogating its regulatory responsibilities to unknown consumer representatives, which is bad.

Response: The Department assumes the comment implies that variance requests will become more common and requests for hearings on variance requests will become more common. The Department does not believe that it will be abrogating its regulatory responsibilities to consumer representatives. California Insurance Code section 1861.05 allows a consumer or his or her representative to request a hearing on a rate application. Because a variance is submitted in connection with a rate application, this section merely recognizes that a consumer may request a hearing on a variance request as he or she may on any other issue set forth in a rate application. The regulations currently allow for variance requests. As it does now, the Department would continue to participate in review and approval of all variance requests.

Commentor Shawna Ackerman, Pinnacle Actuarial Resources, Inc., on behalf of ACIC, PIFC, AIA; September 13, 2006; page 19;
Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 19.

Summary: The comments on this section begin with general remarks, summarizing the regulation and not specific to the proposed regulation changes. The proposed variances are insufficient and there must be a broader variance.

Response: Because this is not a comment on a specific proposed regulation change, a detailed response is not required.

Commentor Shawna Ackerman, Pinnacle Actuarial Resources, Inc., on behalf of ACIC, PIFC, AIA; September 13, 2006; page 19 – 20 and Transcript page 33;
Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 19

Summary: An insurer can be expected to calculate its rates as it normally would and make an alternate calculation using the factors specified in the regulations. The commentor suggests that CDI require filing of both calculations, and allow a variance

when the difference between the insurer's own rate calculation and the CDI rate review calculation exceeded a certain percentage or number of percentage points. The insurer would then detail in the variance request the elements that cause the difference and support for the alternate calculation. CDI could then either approve or deny the variance.

Response: This is similar to the comments requesting a "catch-all" variance and the Commissioner incorporates herein his responses to those comments. The Commissioner has determined that variances must be sufficiently described and articulated so that affected members of the public know what is expected and what will be approved or disapproved. Additionally, the regulations must be sufficiently detailed so that they will be consistently applied. The proposed variance would completely undermine the concept behind the regulations. Requiring the Department to review the company's preferred method for reasonableness would make meaningless the adoption of a single, uniform method of review in order to reduce the administrative burden to a manageable size.

Commentor Shawna Ackerman, Pinnacle Actuarial Resources, Inc., on behalf of ACIC, PIFC, AIA; September 13, 2006; page 20;
Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 20

Summary: Two new variances are proposed by the commentor: one related to reserves ratio and one related to loss development (if there is a significant legal change).

Response: The loss development language has been added to the loss development formula. The Commissioner has determined that a reserves ratio variance is unnecessary.

Commentor Shawna Ackerman, Pinnacle Actuarial Resources, Inc., on behalf of ACIC, PIFC, AIA; September 13, 2006; page 21;
Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 20

Summary: The proposed loss trend variance in 2644.27(f)(10)(c) is overly restrictive. Consideration of any period that creates a better prospective estimate is appropriate. Consideration of data other than paid and closed data should be allowed if shown to create a better prospective estimate.

Response: The limit to periods of at least 10 years is necessary to reduce the Department's administrative burden. In the absence of such a limit, the Department has found that the multitude of options of selecting four quarters or six quarters on up to 24 or more quarters provides almost endless opportunities for targeting or backing into specific desired outcomes and disputes among the various parties over those outcomes. The Commissioner has determined that the regulation as currently proposed, combined with the language of section 2644.7, results in a reasonable balance and allows insurers sufficient flexibility in this area. The comment is rejected.

Commentor Shawna Ackerman, Pinnacle Actuarial Resources, Inc., on behalf of ACIC, PIFC, AIA; September 13, 2006; page 21;
Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 20 – 21.

Summary: The efficiency standard variance in 2644.27(f)(3) is too narrow and too uncertain. It generally does not allow evidence that expenses above the designated level are not due to inefficiency. It is not clear what CDI will accept and there is no mandate that the Department grant a variance when the insurer makes a prima facie case that it provides superior service.

Response: Other than the addition of the language in (C), this variance is essentially the same as the current variance. The Commissioner has determined that the comment is vague and provides no specifics which would allow the Commissioner to evaluate the comment in that context. The comment is rejected.

Commentor Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 21.

Summary: A variance should be recognized which would allow an insurer to seek a higher rate of return if it can demonstrate that its cost of capital exceeds the rate of return used by the Department in the prior approval filing process.

Response: This comment is rejected for the reasons set forth in connection with similar comments made elsewhere in this rulemaking file.

Commentor Russina Sgoureva; Progressive West Insurance Company, September 13, 2006; page 3.

Summary: The regulations preclude insurers from charging rates that will generate adequate risk-adjusted returns. A variance should be added that allows insurers to apply for adjustments to all the factors contained in the regulation which would allow insurers the ability to charge higher rates based on individual circumstances.

Response: The regulations do not preclude insurers from charging rates that will generate adequate risk-adjusted returns. The regulations yield a premium that the insurer should receive from its insureds in order to earn a sum amounting to (1) the reasonable cost of providing insurance and (2) the capital used and useful for providing insurance multiplied by a fair rate of return. This is consistent with the general rule that the rate set for a regulated firm is the sum of (1) its cost of service and (2) its capital base multiplied by a rate of return.

The suggestion that a "catch-all" variance be placed into the regulation is rejected. A variance that would have the effect of rendering the regulation meaningless does not comport with the requirements of Proposition 103. Please see response to similar comments elsewhere in this rulemaking file.

Commentor Russina Sgoureva; Progressive West Insurance Company, September 13, 2006; page 3 – 4.

Summary: An "environmental" rate of return variance should be added to the regulation which would apply where technology is used for mileage verification, to encourage fuel conservation or provides environmental benefits to the people of California.

Response: The Commissioner has determined that allowing a variance for factors that provide environmental benefits are beyond the scope of the proposed regulations.

Commentor Russina Sgoureva; Progressive West Insurance Company, September 13, 2006; page 4

Summary: A variance should be added to allow insurers to seek a higher rate of return if the insurer's cost of capital exceeds the rate of return allowed.

Response: Please see response to similar comments elsewhere in this rulemaking file.

Commentor Russina Sgoureva; Progressive West Insurance Company, September 13, 2006; page 4

Summary: Language should be added to the "mix of business" variance in section 2644.27(f)(1). An insurer should be allowed a variance where it can show that changes to its book of business will impact "any individual rating factor that enters the formula for calculating the maximum permitted premium."

Response: This language is the same as the existing "mix of business" variance and the Commissioner has determined not to propose changes to it at this time. This comment relates to an unchanged portion of the regulations and a more specific response is therefore not required.

Commentor Russina Sgoureva; Progressive West Insurance Company, September 13, 2006; page 4 – 5

Summary: It is appropriate that section 2644.27(f)(2) allows a variance relating to loss control items. However, the burden of "proof" required is too difficult, if not impossible, to meet. Insurers are not able to keep track of all costs associated with loss control activity or to measure with any precision the results of the loss control actions taken. It is the activity itself, rather then the subsequent reduction in losses which should trigger the variance.

Response: This variance is essentially the same as the existing variance. To that extent, please see the response to the comment above. Policyholders should not be required to pay for costs which provide them no benefit. The "burden of proof" is not

difficult. The insurer need only demonstrate that losses have been reduced as a result of the additional expenditures.

Commentor Russina Sgoureva; Progressive West Insurance Company, September 13, 2006; page 5

Summary: The number of personnel, specialized claims systems, specialized claims adjusters and claims service centers in California should be considered cost control efforts for the purposes of the 2644.27(f)(2) loss control variance.

Response: If these are loss prevention and/or loss reduction costs, they can be submitted in connection with this variance.

Commentor Russina Sgoureva; Progressive West Insurance Company, September 13, 2006; page 5

Summary: The regulations require that costs associated with adjusting and other expenses be added to other underwriting expenses and that those costs are subject to the efficiency standard. Since loss control efforts may fall into the category of costs associated with adjusting and other expenses they should not be capped by the efficiency standard. The 2644.27(f)(2) loss control variance should consider costs associated with adjusting and other expenses as loss control within the meaning of the variance.

Response: This variance allows the insurer to recover additional costs. The comment is rejected.

Commentor Russina Sgoureva; Progressive West Insurance Company, September 13, 2006; page 5.

Summary: Adjusting and other expenses (AOE) should not be considered fixed expenses capped by the efficiency standard. AOE should be treated like DCCE. Capping AOE by application of the efficiency standard may result in higher DCCE and loss costs.

Response: The existing regulation includes ULAE in the efficiency standard. The proposed regulation merely updates the terminology to AOE to be consistent with changes in the annual statement.

Commentor Russina Sgoureva; Progressive West Insurance Company, September 13, 2006; page 5

Summary: Insurers should be allowed a variance for higher than average AOE if such additional costs are associated with a comprehensive plan to increase the efficiency of payment of incurred losses as this will reduce claims costs.

Response: To the extent this would be included in the variance set forth in section 2644.27(f)(2), there is not need to further recognize the costs.

Commentor Russina Sgoureva; Progressive West Insurance Company, September 13, 2006; page 6.

Summary: The section 2644.27(f)(3) consumer satisfaction variance is appropriate. However, objective measures of consumer satisfaction are inappropriate. Different insurance consumers, from different market segments, will have different degrees of customer satisfaction. Allowing an insurer to take advantage of this variance should turn on this question: How does a company serving a specific market segment compare to other companies serving that same marker segment.

Response: The Commissioner has determined that objective standards must be imposed to enable fair and consistent application of the regulation. The comment is therefore rejected. Nothing prohibits the objective measures of customer satisfaction to involve a comparison of insurers selling similar products or serving a specific market segment. The comment is rejected.

Commentor Russina Sgoureva; Progressive West Insurance Company, September 13, 2006; page 6

Summary: The section 2644.27(f)(6) entering the marker variance should be expanded to include insurers that grow significantly faster than the rest of the industry in a particular market especially where that growth is in underserved markets. In these cases insurers should not be held to the one million dollar threshold. This would encourage insurers to grow.

Response: This is an existing variance which has simply been moved to the new variance section. There is no reason to expand it to include insurers which are growing faster than the rest of the industry. The comment is rejected.

Commentor Russina Sgoureva; Progressive West Insurance Company, September 13, 2006; page 7

Summary: The section 2644.27 trend variance should be expanded to recognize the impact of the insurer's mix of business. Mix of business factors would include average number of driver points compared to the industry average, where a company insures more exotic, nonstandard, or high performance vehicles, or where a company has fewer drivers than the industry average.

Response: Changes in mix of business are reflected in section 2644.27(f)(10)(A). However, change in mix of business is not compared to industry averages, but to changes in the company's own mix of business. It is a company-specific factor.

Commentor Russina Sgoureva; Progressive West Insurance Company, September 13, 2006; page 7

Summary: The section 2644.27(f)(11) constitutional variance should not be based on confiscation. This variance misreads 20th Century because 20th Century applies only to rollbacks and not to prospective ratemaking.

Response: This language was added in response to public comments requesting such a variance. Therefore, the comment is rejected.

Commentor Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 20 - 21

Summary: The commentor summarizes the allowable variances. Only the change in mix of business variance addresses the broad range of problems that will arise in fitting a cookie cutter formula to the enormously varied Proposition 103 lines.

Response: The Commissioner disagrees that the regulations impose a "cookie cutter" formula. In many respects, the regulations have been changed to reflect company-specific numbers. All insurers use a ratemaking formula to determine their rate needs. To do so is sound actuarial practice. By itself, that does not result in what the commentor appears to negatively characterize as a "cookie cutter" formula. All of the variances are designed to address circumstances where the formula might not yield a correct result.

Commentor Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 21

Summary: An efficiency standard variance is available for service to markets historically inadequately served and a rate of return variance is available for financial investment in markets historically inadequately served. This term is not defined.

Response: The regulation references section 2646.6, which defines underserved community.

Commentor Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 21

Summary: The only rate of return variances are for investment in inadequately served markets and insolvency. The insolvency standard is not adequate to protect insurers from confiscatory rates. There needs to be a rate of return variance based on the inadequacy of the return allowed in section 2644.16 relative to risk.

Response: The variance set forth in section 2644.279f)(11) addresses the commentor's concerns.

Commentor Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 21

Summary: The regulation produces a significantly downwardly biased rate of return. The regulation is likely to produce maximum permitted premiums that do not pass the actuarial straight face test. When a needed rate increase is denied, insurers will end to reduce writings in California.

Response: There is no reason to believe that needed rate increases will be denied, and such a comment is pure speculation. The regulations are designed to ensure that rate applications are approved when they result in rates which fall within the range of reasonable rates.

Commentor Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 22

Summary: A small insurer variance should be included, allowing small insurers to deviate from the regulations for rate of return (if there is no adjustment for company size), projected losses and DCCE (since small insurers are likely to have problems under the one size fits most catastrophe adjustment, loss development, and trend methodologies), efficiency standards (since they have higher expense ratios arising from lack of economies of scale and because small insurers tend to write in niche markets with higher service demands and costs), and earthquake (since they need more than a 1:1 surplus ratio).

Response: The Commissioner has determined that a variance applicable to small insurers is unnecessary. A number of regulatory provisions now authorize use of company-specific numbers. Variances are allowable in a number of areas. The regulations do not specifically negatively impact small insurers. The comment is rejected.

Commentor Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 22 - 23

Summary: A non-typical line variance should be allowed when the rates generated using the input values mandated by the regulation are unreasonable.

Response: The October 5 version of the regulations makes numerous changes relative to specialty lines insurers, which should address the commentor's concerns.

Commentor Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; September 13, 2006; page 23.

Summary: A variance should be allowed for long and short tailed lines. The use of a calendar year model (rather than a more accurate cash flow model) will produce significant bias in the maximum permitted earned premiums for some short and longer tailed lines. In particular, the reserves ratios are build on historical claims data that may be substantially different from a reasonable expected reserve ratio. For example,

payment size and timing shifts that would easily be handled in a cash flow model may not be present in even the most recent loss reserves.

Response: To the extent the comments refer to specialty lines, significant changes were made to the treatment of specialty lines (section 2642.7(c)) in the October 5, 2006, version of these regulations which address the commentor's concerns.

Section 2644.50 Refiling of Approved Rates

Commentor: Pamela Pressley, on behalf of the Foundation for Taxpayer and Consumer Rights (FTCR); September 13, 2006, pages 5-6, Allan I. Schwartz on behalf of The Foundation for Taxpayer and Consumer Rights; September 13, 2006; pages 13-14.

Summary: We support the Commissioner in proactively carrying out by regulation his statutory duty pursuant to CIC §1861.05 to ensure that "no rate shall *remain in effect* which is excessive, inadequate, unfairly discriminatory or otherwise in violation of [Chapter 9]." This provision is especially necessary at a time when homeowners and private passenger automobile insurers are reaping excessive profits and experiencing dismally low loss ratios.

Response: A specific response is not required.

Commentor: Pamela Pressley, on behalf of the Foundation for Taxpayer and Consumer Rights (FTCR); September 13, 2006, pages 5-6;
Allan I. Schwartz on behalf of The Foundation for Taxpayer and Consumer Rights; September 13, 2006; pages 13-14.

Summary: An insurer should be required to justify that its current rates are not excessive by being required to make a rate filing anytime its loss ratios fall below a specified amount. We would be wiling to support a triggering threshold of 65% for private passenger automobile insurance and 60% for homeowners insurance. A 90% triggering threshold for medical malpractice insurance would be appropriate.

Response: The Commissioner has determined that a better way to address the issues which this regulation is designed to address is to provide that, in certain circumstances, as set forth in the regulation, the Commissioner may require an insurer to file a rate application. The approach reflected in the comments was considered during the workshop process, but in response to comments that approach has been revised. The Commissioner has determined that the approach reflected in the regulations appropriately allows the Commissioner to determine that certain existing rates are not excessive and the procedure is not excessively burdensome. Therefore, the comment has not been adopted.

Commentor: Pamela Pressley, on behalf of the Foundation for Taxpayer and Consumer Rights (FTCR); September 13, 2006, pages 5-6;
Allan I. Schwartz on behalf of The Foundation for Taxpayer and Consumer Rights; September 13, 2006; pages 13-14.

Summary: The Commissioner's authority to order a rate filing pursuant to his mandatory statutory duty should not be limited to insurers operating with a rate approved three years ago or longer. The regulation should instead specify that the Commissioner may order a company to file a rate application any time he has reason to believe that a company's rates are no longer in compliance with section CIC §1861.05(a).

Response: The Commissioner agrees that he can examine an insurer's rates at any time to ensure they remain in compliance with applicable California law. However, the Commissioner has determined that including a three-year time frame in this regulation strikes a reasonable balance to address the various concerns that were expressed during the workshop porcess. Therefore, the Commissioner is not amending the regulations in response to this comment.

Commentor: Pamela Pressley, on behalf of the Foundation for Taxpayer and Consumer Rights (FTCR); September 13, 2006, pages 5-6;
Allan I. Schwartz on behalf of The Foundation for Taxpayer and Consumer Rights; September 13, 2006; pages 13-14.

Summary: The regulation should clarify that the insurer shall have the burden of proving that its rate "is justified and meets the requirements of this article [article 10]," including the requirement that no rate shall remain in effect which is excessive, inadequate and unfairly discriminatory as mandated by CIC § 1861.05(a).

Response: The Commissioner has determined that regulation section 2646.5, which addresses burden of proof, adequately addresses this comment. Therefore, further changes are not proposed in response to this comment.

Commentor: Randal Farwell on behalf of Interinsurance Exchange; September 13, 2006, page 9.

Summary: We do not understand the need for this section. The Commissioner is already entitled to request justification for existing rates based on his powers as a regulator.

Response: The Commissioner agrees that he is entitled to request justification. This regulation is designed to provide an efficient method for the Commissioner to determine that existing rates continue to comply with applicable law.

Commentor Kent R. Keller and Steven H. Weinstein, Barger & Wolen, on behalf of AIA, ACIC, PIFC; September 13, 2006; page 21

Summary: The Commissioner lacks authority to order rate filings for approved rates. The "no rate shall remain in effect" language does not give the Commissioner authority to mandate the submission of rate filings. At best, the Commissioner's authority is limited to that set forth in section 1858, et seq.

Response: Section 1858 involves complaints regarding existing rates. It does not address the situation which is addressed in this regulation. It is clear that the Commissioner has authority to ensure that approved rates continue to comply with all legal requirements. This regulation provides a minimal, effective, and efficient way for the Commissioner to perform his statutory duties.

Commentor Russina Sgoureva; Progressive West Insurance Company, dated September 13, 2006; page 9.

Summary: The Commissioner should not be given the authority to require a rate filing where the insurer is using rates that are at least three years old. Proposition 103 contains no language that supports a regulation that allows the Commissioner to require and insurer make a rate filing where the rate was previously approved. Only if an insurer makes a complaint under Cal. Ins. Code section 1858 may the Commissioner require a rate filing. Market forces will require insurers to make rate filing at the appropriate time so no rate filing requirement is necessary.

Response: Please see the response to similar comment, above. Market forces do not always ensure that insurers will seek to reduce or otherwise amend their rates. The Commissioner requires an efficient way to enforce the statutory requirement that no rate remain in effect which does not comply with the relevant law. The comment is rejected.

Section 2646.3 Generic Determinations

No comments were received regarding this section.

Section 2646.4 Hearing on Individual Insurers' Rates

No comments were received regarding this section.

Comments on Unchanged Regulation Sections

Commentor Russina Sgoureva; Progressive West Insurance Company, September 13, 2006; page 10

Summary: The comment relates to section 2644.13, which was not proposed for change in this rulemaking proceeding. The regulations require ancillary income be accounted for. While this is appropriate the regulations fail to recognize “offsets” to ancillary income that should also be considered. Premium earned and not collected detracts from ancillary income. Premium financing may or may not result in ancillary income which impacts the amount of premium reserves available for investing. The better approach would be to use the company specific ancillary income numbers reported on the IEE in the annual statement.

Response: Because this is not a comment on a regulation section proposed to be changed, a response is not required.

Section 2644.16 Rate of Return

The Commissioner may not, legally, approve a rate that is "inadequate." Insurance Code section 1861.05 provides that "[n]o rate shall ... remain in effect which is excessive, inadequate, unfairly discriminatory or otherwise in violation of" specified law. Hence, the law "requires rates within that range which can be described as fair and reasonable ...." (*Calfarm Ins. Company v. Deukmejian, (1989) 48 Cal.3d 805, 822-823.)* "The terms 'fair and reasonable' and 'confiscatory' are antonyms ...." (*Id. at p. 816, fn. 5.)* The range of fair and reasonable rates is defined in light of the insurer's legitimate interest in financial integrity and the insured's legitimate interest in freedom from exploitation. (See *id. at p. 816* [implying that controls on rates must be " 'reasonably calculated to eliminate excessive' " charges to consumers " 'and at the same time provide' " producers " 'with a just and reasonable return on their property' "].) A "confiscatory rate is necessarily an 'inadequate' rate ...." (*Id. at p. 822.)* Therefore, the "general standard" "prohibits ... maintenance of confiscatory rates." (*Id. at pp. 822-823.)*

In prospective ratemaking, the variability in each insurer's cost of capital, among others, is accounted for by allowing the insurer to select any rate it chooses within the zone of reasonableness. An insurer that has a high cost of capital may therefore seek a higher rate of return, so long as it does not exceed the upper bound of the range. If an insurer cannot raise capital at a rate within the zone of reasonableness, consumers are under no obligation to give that insurer a higher rate of return.

Confiscation occurs when the government compels a business to charge a constitutionally impermissibly low rate. Thus, the regulations have been carefully constructed to ensure that the threshold of an *excessive* rate is not so low as to drive insurers' rates down to a confiscatory level. *Inadequate* rates have legal significance only because they represent rates too low, such that the government requires the company to *increase* its rate. An order to increase rates does not implicate the constitutional guarantee against being compelled to lower rates to levels that are not compensatory.

Commenter: Mary B. Gaillard, on behalf of AIG, September 12, 2006, page 1 and 4

Summary: The selection of maximum rate of return for the insurance industry is inherently flawed. In addition, the proposal for having an overall rate of return for all lines does not allow a provision for capital providers' expectation of higher returns on riskier classes of business.

Response: The rate of return methodology has been amended and comments regarding the maximum rate of return are addressed in connection with the October 23 comments and elsewhere in this rulemaking file. The allocation of surplus by line addresses the comment that certain lines are riskier and therefore require a higher rate of return. *20th Century* made it clear that it was not necessary to allow the rate of return to

be driven exclusively by "inherently speculative hypothetical projections of investor expectations." However, the 6% risk premium does, in fact, represent a reasonable determination of investor expectations, based on the historical behavior of investors in insurance companies.

Commenter: Mary B. Gaillard, on behalf of AIG, September 12, 2006, pages 1 and 4.

Summary: The proposal caps the rate of return at 11% for all lines, which may not only be too low, but it also does not include a provision for further review or future change. For this reason, a provision should be included that would allow for periodic review of the rate of return (and if indicated, revision).

In addition, if an insurance product is considered "specialty," the insurer may use an alternative method for projecting losses, other than those specified in sections 2644.5 (catastrophe adjustment), 2644.6 (loss development) and 2644.7 (loss and premium trend). Many of the classes noted under the "specialty" definition would be considered riskier classes of business. An exception for specialty lines should be made to allow for a higher rate of return as calculated by the insurer (and supported to the CDI).

Response: Please see response to similar comments elsewhere in this rulemaking file. The rate of return provisions have been revised in the October version of these regulations. Additionally, significant changes were made regarding specialty lines. Regulations can be revised as appropriate, whether or not a specific revision for further review or future change is included in the regulation text. Therefore, that suggestion was not adopted.

Commenter: Sherman Sitrin, on behalf of AIG, September 12, 2006, page 1, 4

Summary: Having an overall rate of return for all lines does not allow a provision for enough capital for riskier classes of business.

Response: The fact that some lines are riskier than others is reflected in the calculation of different leverage factors by line, as discussed elsewhere in this rulemaking file.

Commenter: Sherman Sitrin, on behalf of AIG, September 12, 2006, page 1, 4

Summary: The Department does not allow for company specific information and actuarial judgment to be fully incorporated into the rate making process. An exception for specialty lines should be made to allow for a higher rate of return as calculated by the insurer and/or supported to the CDI.

Response: The regulations have been amended in response to this and similar comments.

Commenter: Sherman Sitrin, on behalf of AIG, September 12, 2006, page 1, 4

Summary: The selection of the maximum rate of return is flawed and does not have a provision that would allow for further review or further change of the 11%.

Response: In response to this comment the Department is proposing amendment of this section. Additionally, the Department notes that section 2644.27(f)(11) allows a variance where the maximum permitted earned premium would be confiscatory as applied. Other variances, including other rate of return variances, are also recognized.

Commenter: Alexis K. Wodtke, on behalf of Consumer Federation of California (CFC); September 13, 2006; Page 1.

Summary: *20th Century Ins. Co v. Garamendi* (1994), 8 Cal. 4th 216, made clear the Commissioner's obligation to protect consumers as well as insurers' financial interests. Certain elements of the 20th Century decision are as applicable to prior approval ratemaking as to rollbacks. A 'legitimate and rational goal of price or rate regulation is the protection of consumer welfare. The investor's interest in earning enough revenue not only for operating expenses but also for the capital costs of the business is 'only one of the variables in the constitutional calculus of reasonableness.' It is an interest investors pursue, but not a right they can demand.' Consumers also have a right to be free from exploitation. In balancing the relevant producer and consumer interests for a just and reasonable rate, one is concerned with a "broad zone of reasonableness" and not with any particular point therein. 'So long as rates as a whole afford (the regulated firm] just compensation for [its] over-all services to the public,' they are not confiscatory. [citations omitted.]

Response: The Commissioner agrees with this comment and believes the regulations are in accord.

Commenter: Allan I. Schwartz, on behalf of the Foundation for Taxpayer and Consumer Rights), pages 8-9; oral statement of Allan Schwartz (FTCR), September 13, 2006, transcript pages 53-57.

Summary: The 11 percent rate of return is reasonable, if not somewhat high. An appropriate analysis based upon consideration of various financial issues including the Capital Asset Pricing Model (CAPM), Discounted Cash Flow (DCF) Model, cost of debt and the weighted average cost of capital indicates that a reasonable rate of return is less than 10%.

The long term historical return on surplus for property casualty insurers is just under 11%. However this is during a period of time when the average investment asset return for property casualty insurance companies was about 8%. Given that the investment returns currently available are lower than the long term average, the return to insurers should also be lower than the long-tem average. This supports a maximum rate of return allowance to insurers of less than 11%.

Response: The Commissioner generally agrees with this comment, and incorporates by this reference his responses to other comments in this rulemaking file, including the October 23 comments.

Commenter: Allan I. Schwartz, on behalf of the Foundation for Taxpayer and Consumer Rights, pages 8-9; oral statement of Allan Schwartz (FTCR), September 13, 2006, transcript pages 53-57

Summary: The issue is not whether there is a cap or not a cap, the issue is how are you going to determine what rate of return is going to be allowed in the rate level. If you don't set something forth in regulation (e.g., include a number or some methodology), you will have an *ad hoc* determination from one rate filing or one rate hearing to another. Thus, not addressing the rate of return in the regulation is not going to get rid of the issue of what the cap is and what the appropriate rate of return is, but rather shift from something that everyone knows beforehand to something there will be uncertainty about because it will have to be decided on each individual filing separately.

Response: The Commissioner agrees with this comment.

Commenter: Allan I. Schwartz, on behalf of the Foundation for Taxpayer and Consumer Rights), pages 8-9; oral statement of Allan Schwartz (FTCR), September 13, 2006, transcript pages 53-57

Summary: In response to another comment that if the 11 percent maximum is used, then what companies earn is going to have to fall below that number because 11 percent is the maximum, the person who made that statement might have been confused about what the 11 percent actually applies to: what you put in the rate indication. On an after-the-fact basis, some of those companies may make more than 11 percent and some of them may make less than 11 percent (i.e., the fact that 11 percent is the highest number you can put in the rate indication does not mean that is the highest number the companies are going to earn).

Response: The Commissioner generally agrees with this comment.

Commenter: Allan I. Schwartz, on behalf of the Foundation for Taxpayer and Consumer Rights), pages 8-9; oral statement of Allan Schwartz (FTCR), September 13, 2006, transcript pages 53-57

Summary: Contrary to another comment regarding the Fama-French Three Factor method replacing the capital asset pricing model, the capital asset pricing model is still the method that's commonly used. The capital asset pricing method is often used by regulators, and such a model indicates a rate of return for insurers of less than 11 percent.

Response: The Commissioner generally agrees with this comment and incorporates herein his other rate of return responses found elsewhere in this rulemaking file.

Commenter: Allan I. Schwartz, on behalf of the Foundation for Taxpayer and Consumer Rights), pages 8-9; oral statement of Allan Schwartz (FTCR), September 13, 2006, transcript pages 53-57

Summary: The number given for the rate of return from the Fama-French Three Factor model of 17 percent given by another commenter is highly excessive. If you look at what insurers actually earn or at various financial models, such as the capital asset pricing model, they take into account the cost of debt in a way that average cost of capital is generally less than 10 percent. An independent check on that can be done with a service provided by Ibbotson Associates, which is commonly used for doing the market risk premium capital asset pricing model and also provides costs of capital calculations for various industries (using different methods).

Response: The Commissioner generally agrees with this comment. However, the Commissioner notes that the familiar analyses based on the Ibbotson data have been found by the Department to have an inherent bias that overestimates insurers' cost of capital. The Ibbotson data are typically used, as they have been in comments by Appel, Cummins, and others in this docket, in conjunction with a sample of firms reported by Value Line. The Department has determined that this Value Line sample has enjoyed returns higher than a representative sample of the property-casualty insurance industry as a whole.

Commenter Pamela Presley and Allan I. Schwartz on behalf of the Foundation for Taxpayer and Consumer Rights, September 13, 2006 (all rate of return comments reference the comments from Allan Schwartz) page 8-9, Transcript at page 53 to 57

Summary: The commenters believe that 11% is somewhat high but reasonable and that a reasonable rate of return is less than 10%. The commenter notes that CAPM is still the method most commonly used in insurance pricing and regulations to set the rate of return. The commenter discusses the uncertainty in rate of return projections such that actual realized numbers will be both above and below the projection. Attachment schedule AIS-4, sheet one shows a rate of return for property-casualty insurers from 1983 to 2004 of 10.8%. The exhibit entitled "Weighted Average Cost of Capital for Fire, Marine, and Casualty Insurance" shows the composite cost of capital in the 2006 Ibbotson yearbook calculated under various methodologies as follows: CAPM 8.67%, CAPM plus size premium 9.56%, Fama-French Three-Factor Method 9.39%, Discounted Cash Flow 1-Stage 10.03%,Discounted Cash Flow 3-Stage 11.81%, average of all of the proceeding is 9.89% showing support for 11% figure.

Response: No response is necessary as the commenter supports the regulation.

Commenter Randy Farwell on behalf of the Inter-Insurance Exchange of the Automobile Club, September 13, 2006; page 1 - 2

Summary: The rate of return number should have the capability to change when conditions change. Further research should be done to determine the proper approach.

Response: In response to this comment the Department is proposing amendment of this section to reflect changing interest rates. Additional material has been added to the rulemaking file in connection with this proposed change.

Commenter: Randall Farwell on behalf of Interinsurance Exchange of the Automobile Club., September 13, 2006; pages 1-2, 5.

Summary: While a fixed rate of 11% is better than the prior proposal, we believe some further adjustments to this section are warranted to better reflect changing conditions. We recommend consulting additional resources, such as the Casualty Actuarial Society research library. There are numerous approaches to assessing the target rate of return, and we think the Department could revise the proposed regulation with additional research. The selected rate of return should adjust based on the related risks of the line of business and the updated market conditions. A static value does not meet this need.

Response: This section has been changed in the October 5 version, and the Commissioner therefore refers to and incorporates his responses to the comments submitted on the October 5 version of these regulations.

Commenter: Randall Farwell on behalf of Interinsurance Exchange of the Automobile Club., September 13, 2006; pages 1-2, 5.

Summary: As opposed to using a fixed value of 11%, the Department could allow carriers to use either the Capital Asset Pricing Model or the Dividend Yield Method. An average of the two methods should also be acceptable. These methods produce reasonable rates of return that reflect projected investment returns and risk premiums. The selected rate of return would adjust based on updated market conditions instead of being a static value.

Response: This section has been changed in the October 5 version, and the Commissioner therefore refers to and incorporates his responses to the comments submitted on the October 5 version of these regulations. The rate of return provision in the October 5 version does adjust based on market conditions, as suggested by the commenter. The commenter supports the Capital Assets Pricing Model, and the Commissioner agrees.

Commenter: Kent R. Keller, Roxani M. Gillespie, Robert J. Cerny, Barger & Wollen, on behalf of 21st Century Insurance Company; September 13, 2006; page 11 – 12

Summary: The regulations provide no method for CDI to consider the single issue of foremost importance to the consumer – the price of coverage, the ultimate standard under CIC section 1861.05(a) – in determining whether a rate is excessive. This, along with the regulation's policy of restricting a rate of return, leads to absurd consequences, where an insurer charging a higher rate (with a rate of return below the maximum) obtains approval

from the CDI, but an insurer charging a lower rate (with an "excessive" rate of return) does not.

To alleviate this price anomaly, CDI should add a new subsection (6) to section 2644.27 as follows:

"(6) That the insurer should be authorized a maximum permitted rate of return greater than the maximum permitted rate of return determined pursuant to §2644.16 if it can demonstrate that the average rate level requested in the insurer's rate application for that line of insurance is lower than the average rates previously approved by the Commissioner for 8 of the largest 20 insurers in the California market in that line, based on the previous year's annual written premium, as determined by the most recent price survey for that line conducted by the Commissioner. To qualify for this variance, the insurer shall also demonstrate that its standard coverage is at least equal to the average standard coverage provided in the overall market for that line."

Response: The 21st Century recommendation would allow an insurer that specializes in low-cost, low-risk customers to achieve excessive profits and would encourage companies to shun higher-risk customers in order to obtain unfairly high profits. Furthermore, to be intellectually honest, the proposal should contain its mirror-image, a prohibition on very high rates irrespective of possibly low profits derived from those rates. Obviously the latter approach would risk a confiscatory result, but the absence of this recommendation leaves the comment wholly one-sided in favor of insurers and against consumers. The fact remains that the California Supreme Court – at the urging of the insurance industry – required the Commissioner to regulate rates on the basis of costs and rate of return. An insurer that specializes in low-risk policyholders may prefer a different regulatory standard, but it is too late in the day for the Commissioner to entertain that proposal.

Commenter: Kent R. Keller, Roxani M. Gillespie, Robert J. Cerny, Barger & Wolen, on behalf of 21st Century Insurance Company; September 13, 2006; page 3

Summary: There is a significant question whether Proposition 103 authorizes a formulaic approach restricting rate of return.

Response: The *20th Century* case emphatically answered this question in the affirmative.

Commenter: Kent R. Keller, Roxani M. Gillespie, Robert J. Cerny, Barger & Wolen, on behalf of 21st Century Insurance Company; September 13, 2006; page 9

Summary: The use of an average rate of return to set the maximum rate of return will force the average lower over time.

Response: The fallacy with this comment is that it assumes that the rate of return sought by the insurer in its rate application is what will actually be exceeded or

undershot. The rate of return target is a projection. Sometimes the insurer will realize a higher return and sometimes a lower return such that over time there will not be a downward bias. Please see comments of Allan Schwartz, Transcript at page 54, line 10 through page 55, line 4.

Commenter: Kent R. Keller, Roxani M. Gillespie, Robert J. Cerny, Barger & Wolen, on behalf of 21st Century Insurance Company; September 13, 2006; page 9

Summary: Using an average historical return to define an excessive return is odd. The regulation suggests that any rate even slightly higher than the historical average is excessive and therefore prohibited. This is an abuse of discretion in interpreting section 1861.05(a). The practical effect of limiting rate of return in this way will cause investors to search for greater returns elsewhere.

Response: The rate of return must be such that it would allow insurers to attract capital. The *20th Century* court, in accepting the testimony of the Department's witness Dr. Andrew Safir, noted his opinion that investors' expectations were largely shaped by historic profit levels of the companies making up the industry. Therefore, use of the past average historical rate would not cause investors to seek returns elsewhere.

Commenter Michael A. Walters, Towers Perrin, on behalf of the Association of California Insurance Companies; September 13, 2006; page 17

Summary: A uniform 11% target rate of return is not demonstrated to be appropriate. Why is a uniform target return on equity appropriate since some lines are obviously riskier than others. Given the greater fluctuation in returns, why wouldn't the property casualty industry be given the opportunity to earn more than the average industry?

Response: Allowing insurers a different leverage ratio for a riskier line allows them to earn more such that a separate rate of return adjustment is not necessary. The *20th Century* court, in accepting the testimony of the Department's witness Dr. Andrew Safir, noted his opinion that investors' expectations were largely shaped by historic profit levels of the companies making up the industry. Therefore, use of the past average historical rate would not cause investors to seek returns elsewhere. According to its beta, the property and casualty industry is generally considered no riskier than the stock market as a whole. There is no evidence that the insurance industry is riskier than average. Some industry commenters have argued that the industry is of average risk. No other commenter has argued or provided any support for the notion that it is above average. Department studies added to the rulemaking file provide support for the argument that the industry is below average risk.

Commenter Michael A. Walters, Towers Perrin, on behalf of the Association of California Insurance Companies; September 13, 2006; page 17

Summary: Setting a target doesn't always mean that it is achieved. Is there room for a contingency factor?

Response: Setting in the target works both ways. Sometimes the insurer will achieve more than the selected return and sometimes less. Allowing a contingency factor when failing to achieve the selected rate of return would also logically necessitate the refund of premium to policyholders when the actual return is higher than the average. Separate explicit contingency factors are a relic of the past of actuarial ratemaking and have been out of favor for at least 30 years.

Commenter: J. David Cummins, September 13, 2006, page 1, 3, 5 - 6; and Kent R. Keller and Steven H. Weinstein of Barger and Wolen, September 12, 2006, on behalf of PIFC, ACIC and AIA

Summary: Adoption of a fixed maximum after-tax permitted rate of return is inappropriate because it does not recognize that the rate of return varies over time due to changing interest rates and other economic conditions.

Response: In response to this comment the Department is proposing amendment of this section to allow the rate of return to vary over time.

Commenter: J. David Cummins, September 13, 2006, page 1, 3; and Kent R. Keller and Steven H. Weinstein of Barger and Wolen, September 12, 2006, on behalf of PIFC, ACIC and AIA

Summary: An 11% rate of return is an inadequate fair rate of return

Response Please see response to similar comment below.

Commenter: J. David Cummins, September 13, 2006, page 4, 6 and Kent R. Keller and Steven H. Weinstein of Barger and Wolen, on behalf of PIFC, ACIC and AIA September 12, 2006, page 1, 7, 23

Summary: The regulations fail to provide for a rate of return that is "commensurate with the returns on investment in other enterprises having corresponding risks." Federal Power Commission v Hope Natural Gas Company (1944) 320 U.S. 591.

Response: As set forth elsewhere in this rulemaking file, the 11% figure in the regulations is fully supported as providing a fair rate of return that will attract capital and is comparable to that of other enterprises having similar risks. In fact, while Dr. Cummins states that a 17.1% rate of return is indicated by his calculations, he only arrives at that number by including much higher costs of capital in prior years. If one looks at 2005, Dr. Cummins calculated a 14.38% rate under the Fama-French Three Factor method and a 13.87% rate using the Full-Information Beta method. That is similar to the figure used by the Department (11%) or in the returns calculated by Mr. Derrig in his comments when he updated the numbers for the method used by Dr. Appel in the Safeco hearing. The result of updating the numbers was a discounted cash flow estimate of 11% and CAPM estimate of 12.59%.

It is important to examine *20th Century Insurance Co.* v *Garamendi* (1994) 8 Cal.4th 216

(repeatedly quoted by the insurers in their comments), the California Supreme Court case which applied the *Hope* standard to California insurance rate regulation. That decision noted at page 303 that "determining rates of return is not an exact science, and indeed requires exercise of judgment." The decision went on to note that the two prior commissioners, Commissioner Gillespie and Commissioner Garamendi, both arrived at different numbers but both numbers were reasonable. As noted in the documents provided with the 15 day Notice, there is additional, reasonable evidence that would support a rate of return of 9.44%. While that document shows that calculation, the Commissioner's choice of the risk premium in the October version of these regulations resulted in the adoption of a rate of return 1 and 1/2 percent greater than that. This recognizes that selecting a rate of return number is not an exact science and in the exercise of reasonable discretion, the number selected was between the various estimates.

Commenter: J. David Cummins, September 13, 2006, page 1-2, 6-8 and Kent R. Keller and Steven H. Weinstein of Barger and Wolen, on behalf of PIFC, ACIC and AIA, September 12, 2006

Summary: Using historical accounting data is inaccurate and will not provide insurers with an adequate rate of return.

Response The Commissioner has determined that historical data is relevant in determining an appropriate and adequate rate of return, for the reasons set forth in *20th Century*. The rates of return calculated in accordance with statutory accounting principles (SAP) are similar to those calculated using generally accepted accounting principles (GAAP). One problem with using market rates, as advocated by these Commenters, is that the data needed for that analysis does not exist for mutual or reciprocal insurers. The Department requires a consistent methodology that can be applied to the entire industry, including mutual and reciprocal insurers. Also, even the method used by Dr. Cummins uses long-term averages of returns. (J. David Cummins, September 13, 2006, page 11.)

Commenter: J. David Cummins, September 13, 2006, page 2-3 and Kent R. Keller and Steven H. Weinstein of Barger and Wolen, on behalf of PIFC, ACIC and AIA, September 12, 2006

Summary: The fair rate of return should be based on a methodology that reflects market rates of returns and uses principles of modern financial theory.

Response: The value of a business, the income it earns, and its cost of capital is not solely reflected by market values. Underlying any careful determination of a market value is an analysis of the underlying entity's financial accounting records and books. In fact, one can argue from recent past experience, that using market rates of return provide an inaccurate fair rate of return and that an analysis of the accounting data would have resulted in a much more accurate cost of capital estimate. Also, the cost of capital figure generated by the method suggested Dr. Cummins is similar to the rate of return calculated by the CAPM method and the figure proposed by the Department. Uncertainty exists in the calculation regardless of the method chosen.

Commenter: J. David Cummins, September 13, 2006, page 6 and Kent R. Keller and Steven H. Weinstein of Barger and Wolen, September 12, 2006, on behalf of PIFC, ACIC and AIA

Summary: Using an average to set the maximum rate of return will have the effect of gradually reducing what that average is.

Response: The fallacy with the Commenter's argument is that the rate of return sought by the insurer in its rate application is a projection. Sometimes the results are lower, and sometimes the results are higher than the projection. Therefore, even with a set maximum rate of return, insurers will sometimes earn above that average and sometimes earn below that average. No company is required to file for a rate less than the cap. If the argument is true, any cap, no matter how high, would reduce the average. There is no mechanism in the regulations that reduces the 6% risk premium even if the average is reduced. California Proposition 103 lines are only a small part of the national, all-lines averages that were contained in the studies added to the rulemaking file, so any reduction on those averages would be immaterial.

Commenter: J. David Cummins, September 13, 2006, and Kent R. Keller and Steven H. Weinstein of Barger and Wolen, on behalf of PIFC, ACIC and AIA, September 12, 2006, page 22

Summary: The Commissioner no longer provides a description of the process for determining the rate of return. The prior version of the regulation expressly stated the basis for the allowable rate of return as based upon the "risk premium" plus the "risk-free" rate

Response: In response to this and similar comments, the Department is proposing amendment of this section.

Commenter: J. David Cummins, September 13, 2006, page 6 and Kent R. Keller and Steven H. Weinstein of Barger and Wolen, on behalf of PIFC, ACIC and AIA, September 12, 2006, page 23

Summary: There is an inherent bias in selecting a fixed maximum rate of return based on historical average rates of return.

Response: In response to this and similar comments, the Department is proposing amendment of this section. In addition, because the target rate of return sought by the insurer is a projection with uncertainty surrounding it, sometimes the subsequent realized return will be greater than the allowed maximum rate of return and sometimes it will be less. Therefore there is not an inherent bias placing downward pressure on the average. Furthermore, historical returns are employed by virtually all commenters, including industry commenters – they all derive their recommended risk premium from historical data. The Department also incorporates herein by this reference its Responses to similar comments, above.

Commenter: J. David Cummins, September 13, 2006, and Kent R. Keller and Steven H.

Weinstein of Barger and Wolen, on behalf of PIFC, ACIC and AIA, September 12, 2006

Summary: The minimum non-confiscatory rate set in 1989 by the Commissioner was 10%. Today the Commissioner is proposing that the maximum fair rate of return be only 1% above that, or 11%. That there is only a 1% difference between the minimum non-confiscatory rate and the maximum fair rate of return defies common sense and is wrong.

Response: The commenter is mistaken in his belief that the minimum non-confiscatory rate should be substantially below an excessive rate. Furthermore, the 1989 rate of return applied to capital markets in which the risk-free rate was roughly twice what it is today. The Commissioner finds the commenter's comparison not to be relevant.

Commenter Richard Roth, Jr., September 11, 2006 page 2, 4

Summary: The 11% maximum rate of return is the most egregious section in the regulations. Over time it will force the actual rate of return to be significantly less than 11%. These regulations should allow a range at the 90th percentile around 11%.

Response: One fallacy with this comment is that it assumes that the rate of return sought by the insurer in its rate application is what will actually be achieved or undershot. The rate of return target is a projection. Sometimes the insurer will realize a higher return and sometimes a lower return such that over time there will not be a downward bias. Please see comments of Allan Schwartz, Transcript at page 54, line 10 through page 55, line 4. The exhibits submitted by this commenter actually support the selection of an 11% rate of return. Table A shows that the average rate of return from 1977 to 2004 was 11.8% and the average rate of return from 1984 to 2004 was 9.8%. Table D. shows a return on book value for selected publicly traded insurance companies of 11%. The *20th Century* court, in accepting the testimony of the Department's witness Dr. Andrew Safir, noted his opinion that investors' expectations were largely shaped by historic profit levels of the companies making up the industry. Therefore, use of the past average historical rate would not cause investors to seek returns elsewhere.

Commenter Russina Sgoureva; Progressive West Insurance Company, September 13, 2006; page 1

Summary: Progressive offers a rate to virtually every driver in California. We incur more risk yet are constrained by a generic rate of return that is based, in part, upon industry average accounting data.

Response: In part, an insurer writing riskier policyholders will experience greater losses, which are reflected in the ratemaking formula. To the extent that servicing these risks results in greater expenses, please see the Department's responses regarding the efficiency standard and the variance provided in section 2644.27 (f)(3). Additionally, these regulations provide for a rate of return variance when the insurer's mix of business presents investment risk different from the risks typical line of the line as a whole provided that the insurer writes at least 90% of its direct premium in one line or in

California. If the commenter is saying that Progressive has a more diverse portfolio of risks, the appropriate inference is that Progressive is reducing its risk through diversification.

Commenter Russina Sgoureva; Progressive West Insurance Company, September 13, 2006; page 2

Summary: An 11% rate of return is insufficient to allow companies to attract capital. An inadequate rate of return will lead to diminished competition and higher rates.

Response: Please see response to similar comments elsewhere in this rulemaking file.

Commenter Russina Sgoureva; Progressive West Insurance Company, September 13, 2006; page 2

Summary: A -7% will result in rates that are inadequate, would threaten solvency and promote predatory pricing.

Response: The rulemaking file has been supplemented with a study that, via regression analysis, shows that companies are able to maintain their surplus with a -6% return. The regulations do not force any company to file for a -6% return. Occasionally, for competitive reasons, companies will choose to lose money in the short term in order to gain market share and make more money in the long term. The -6% establishes a reasonable floor so that companies will be able to maintain their surplus and solvency.

Commenter Russina Sgoureva; Progressive West Insurance Company, September 13, 2006; page 2

Summary: A market based model should be used for calculating the rate of return. If CDI proceeds with the regulations as drafted, a variance should be added that permits a higher return where the insurer can demonstrate that the returns demanded for its equity by the capital market exceed the maximum rate of return the regulations allow.

Response: The variance comment is addressed in connection with the responses to comments made regarding the variance provisions of section 2644.27(f), incorporated herein by this reference. The reference to the market based model refers to the Fama-French Three-Factor method advocated by Dr. Cummins, and the Commissioner incorporates herein by this reference his response to other comments regarding that method.

Commenter Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; The Doctors Co., Nationwide Mutual Insurance Co., Allied Insurance Company and Oregon Mutual Insurance Co., September 13, 2006; page 2, 11

Summary: The regulation (inter alia, rate of return) establishes some mandated values without evidentiary input and without an opportunity for insurers to review the values in the underlying data.

Response: In response to this and other similar comments, the Department added information to the rulemaking file, including the values in the underlying data, and solicited public comment on that information

Commenter Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; The Doctors Co., Nationwide Mutual Insurance Co., Allied Insurance Company and Oregon Mutual Insurance Co., September 13, 2006; page 3, 22

Summary: Setting a maximum permissible rate of return at or near the average value over a range of typical insurers is flawed. There should be a variance to allow a higher rate of return for companies that legitimately pose a higher than average risk.

Response: Giving insurers a different leverage ratio for a riskier line allows them to earn more such that a separate rate of return adjustment is not necessary. The regulations provide a rate of return variance in section 2644.27(f)(5) for an insurer writing at least 90% of its direct premium in one line or in California and its mix of business presents investment risks different from the risks that are typical of the line as a whole. In fact, section 2644.27(f) authorizes 11 different variances, including a variance where the maximum permitted earned premium would be confiscatory as applied.

Commenter Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; The Doctors Co., Nationwide Mutual Insurance Co., Allied Insurance Company and Oregon Mutual Insurance Co., September 13, 2006; page 12

Summary: The use of an average as a maximum will always lead to an actual average as applied below the originally calculated average.

Response: The fallacy with this comment is that it assumes that the rate of return sought by the insurer in its rate application is what will actually be achieved. The rate of return target is a projection. Sometimes the insurer will realize a higher return and sometimes a lower return. Please see comments of Allan Schwartz, Transcript at page 54, line 10 through page 55, line 4.

Commenter Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; The Doctors Co., Nationwide Mutual Insurance Co., Allied Insurance Company and Oregon Mutual Insurance Co., September 13, 2006; page 4, 14

Summary: The regulations are systematically biased against smaller insurers that, like other smaller companies, have a substantially higher cost of capital. Over time, the

regulations will tend to reduce the number of insurers in California and produce a market dominated to an ever increasing degree by a small number of large insurers with large market shares.

Response: The commenters have failed to offer any credible evidence on which to base an expectation of a diminishing number of insurers due to these regulations. Milo Pearson, on behalf of the Pacific Association of Domestic Insurance Companies, commented that from 1999 to 2004 there were 28 fewer domestic insurers in California, itself a very small percentage decrease. And what Mr. Pearson was unable to demonstrate was that any of this reduction was due to the formulaic approach to rate making in the Department regulations, which has existed for at least the last 15 years. Many of the companies referenced by Mr. Pearson wrote workers compensation insurance which is not regulated by Proposition 103 and is subject to an entirely different regulatory system. This comment is speculative and the commenter has also not shown any small companies that stopped writing in California in the last 15 years due to the Department's rate approval regulations. A previous version of the regulations presented in a workshop provided an explicit adjustment of the return based on size, with smaller companies getting a larger return. Several commenters said that such a size adjustment, while possibly appropriate for market returns, was not appropriate for the book return. The variance set forth in section 2644.27(f)(5) for mono-state, mono-line insurers covers virtually all of the smaller insurers.

Commenter Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; The Doctors Co., Nationwide Mutual Insurance Co., Allied Insurance Company and Oregon Mutual Insurance Co., September 13, 2006; page 12 to 13

Summary: The 11% fixed return is too low and is already out of date. The Department should adopt the Safeco methodology rather than the Safeco number. A fixed rate of return is inconsistent with the prospective investment income yield.

Response: In response to this comment the Department is proposing amendment of this section. The Department would note that the attachments to this commenter's comments showed that the updated number for the cost of capital under the discounted cash flow analysis went from 9.61 to 11%. The cost of capital went from 11.16% to 12.59% when 2006 updated data is used. All of these numbers support the selection of 11% being in the range of reasonable returns.

Commenter Hilary N. Rowen, Thelen Reid & Priest, and Richard A. Derrig, OPAL Consulting, on behalf of four specific insurers; The Doctors Co., Nationwide Mutual Insurance Co., Allied Insurance Company and Oregon Mutual Insurance Co., September 13, 2006; page 14

Summary: A minimum rate of return of -7% is silly. Such a result would deplete the surplus of the insurer and it would then face insolvency.

Response: The purpose of the minimum rate of return is to identify the level below which the Commissioner would require the insurer to raise its rates to avoid inadequacy. So the first observation to be made is that while the commenters would find a -7% rate of return "silly," the figure is important only when an insurer has itself chosen to price its product at a level expected to yield that profit. The October 5, 2006, version of these regulations amends the minimum permitted after-tax rate of return to -6%. The regulations do not force any company to file for a -6% return. Occasionally, for competitive reasons, companies will choose to lose money in the short term in order to gain market share and make more money in the long term. The -6% establishes a reasonable floor so that companies will be able to maintain their surplus and solvency. A study added to the rulemaking file in October demonstrates via regression analysis that companies are able to maintain their surplus with a -6% return.

Commenter: William K. Johanneson, on behalf of Farmers Insurance Group, September 13, 2006, page 1, 5-6

Summary: The regulations prevent insurers from receiving commensurate returns as earned by other enterprises having corresponding risks as required by the *Hope* case.

Response: See response to similar comment by J. David Cummins, September 13, 2006, page 4, 6 and Kent R. Keller and Steven H. Weinstein of Barger and Wolen, September 12, 2006, page 1, 7, 23 on behalf of PIFC, ACIC and AIA.

Commenter: William K. Johanneson, on behalf of Farmers Insurance Group, September 13, 2006, page 5-6

Summary: The regulation should not use an average of the historical returns as the basis for determining the maximum allowable prospectively targeted rate of return.

Response: The *20th Century* court in accepting the testimony of the Department's witness, Dr. Andrew Safir, noted that expert's opinion that investors' expectations were largely shaped by historic profit levels of the companies making up the industry. Therefore, use of the past average historical rate would not cause investors to seek returns elsewhere

Commenter: William K. Johanneson, on behalf of Farmers Insurance Group, September 13, 2006, page 5-6

Summary: The regulation is highly inflexible as it has incorporated an exact rate of return percentage into the regulations which does nothing to allow for the impact of variation in the risk-free rate or variations by line of business

Response: In response to this comment the Department is proposing amendment of this section. For variations in risk by line please see section 2644.17, Leverage Factors and Surplus.

Commenter: William K. Johanneson, on behalf of Farmers Insurance Group, September 13, 2006, page 6

Summary: Since the targeted return can be no more than the average stated in the regulations, over time the average will decrease since insurers cannot target a return above the average.

Response: The fallacy with this comment is that it assumes that the rate of return sought by the insurer in its rate application is what will actually be achieved. The rate of return target is a projection. Sometimes the insurer will realize a higher return and sometimes a lower return. Please see comments of Allan Schwartz, Transcript at page 54, line 10 through page 55, line 4.

Commenter: William K. Johanneson, on behalf of Farmers Insurance Group, September 13, 2006, page 6

Summary: The average return chosen by the Department is made up of results both above and below the average. Mandating that insurers can select no higher than the average will limit the ability of insurers to achieve above that average return so that over time there will be a downward bias below the average.

Response: The fallacy with this comment is that it assumes that the rate of return sought by the insurer in its rate application is what will actually be achieved. The rate of return target is a projection. Sometimes the insurer will realize a higher return and sometimes a lower return. Please see comments of Allan Schwartz, Transcript at page 54, line 10 through page 55, line 4.

Commenter: William K. Johanneson, on behalf of Farmers Insurance Group, September 13, 2006, page 1, 5-6

Summary: Although the Department has chosen a rate of return several points above the average historical realized returns, this still does nothing to address the influence of the risk-free rate which has exceeded the proposed maximum of 11% on two separate occasions within the past 30 years.

Response: In response to this and similar comments, the Department is proposing amendment of this section.

Commenter: William K. Johanneson, on behalf of Farmers Insurance Group, September 13, 2006, page 6

Summary: The regulations should recognize different rates of return for different lines of business depending upon risk. The Fama-French Three-Factor model does recognize that difference and should be used by the Department.

Response: The different leverage ratios by line accomplish this for riskier lines.

Commenter: William K. Johanneson, on behalf of Farmers Insurance Group, September 13, 2006, page 6

Summary: The use of industry-wide leverage and surplus factors punishes highly capitalized companies by artificially suppressing their rates of return.

Response: In response to this comment the Department is proposing amendment of the leverage ratios. The regulations' focus on used and useful surplus does not prevent an insurer her from having more surplus, but it cannot earn a return on that excess surplus. The Supreme Court approved in *20th Century* limitation of a return on capital to the amount of capital used and useful in providing the regulated insurance, which the regulations continue to do.

Commenter: Peter Bang, Keefe, Bruyette and Wood; Transcript at page 6-14.

Summary: The property and casualty insurers' rates of return have a lot of variability over the years. Investors are willing to put their capital in them because they make up for a lot of bad years by a few very good years. Capping the return that they can achieve at the average for all of those years will prevent the insurers from obtaining the extra good returns they achieve in a few of those years. This will cause them to be unable to compete for capital.

Response: Ratemaking is prospective. Under actuarial principles, rates in one year are not set above the prospective costs in order to recoup losses in past years. Nor are rates set lower than prospective costs in order to rebate high profits from past years. The fallacy with this comment is that it assumes that the rate of return sought by the insurer in its rate application is what will actually be achieved. The rate of return target is a projection. Sometimes the insurer will realize a higher return and sometimes a lower return. Please see comment of Allan Schwartz, Transcript at page 54, line 10 through page 55, line 4.

Commenter: Keesha-Lu M. Mitra, Judith K. Mintel and Vanessa Wells, Heller Ehrman, on behalf of State Farm.; September 13, 2006; page 1

Summary: If rates are to be regulated based on a rate of return, that return should not vary based on whether the insurer is a mutual insurance company, a publicly traded stock corporation, a privately held stock corporation, or organized in any other way.

Response: No response is necessary as this is what the Department's regulations provide.

Commenter: Michael J. D'Arelli, on behalf of Western Insurance Agents Association; September 13, 2006; page 1-3

Summary: The 11% rate of return mandates in theory a rate of return for insurers doing business in California which will make it impossible for insurers to achieve returns that correlate with businesses of comparable risk. The 11% randomly establishes an industry-wide rate of return for insurers which lacks the support of serious empirical data.

Response: Please see response to comment immediately above. Additionally, in response to comments such as this one, the Department has added additional information to the rulemaking file and has solicited comments on that information.

Commenter: Milo Pearson and Christian Rataj, on behalf of the Pacific Association of Domestic Insurance Companies (PADIC) /National Association of Mutual Insurance Companies (NAMIC); September 12, 2006; page 4

Summary: We are ideologically opposed to the Department interfering in free-market economics by imposing an arbitrary maximum and minimum rate of return for insurance carriers.

Response: This approach has already been mandated by the voters in enacting Proposition 103 and approved by the California Supreme Court in the *20th Century* (1994) 8 Cal.4th 218, 302 et seq.

Commenter: Milo Pearson and Christian Rataj, on behalf of the Pacific Association of Domestic Insurance Companies (PADIC) /National Association of Mutual Insurance Companies (NAMIC); September 12, 2006; page 4-5

Summary: The minimum and maximum rates of return were arbitrarily established and the Department did not adequately list the factors making up that determination.

Response: In response to this and similar comments, the Department added information to the rulemaking file and invited public comment on that information.

Commenter: Milo Pearson and Christian Rataj, on behalf of the Pacific Association of Domestic Insurance Companies (PADIC) /National Association of Mutual Insurance Companies (NAMIC); September 12, 2006;
Peter M. Cazzolla, President-CEO of CIG, Transcript at page 18, lines 8-9
David Appel, on behalf of PADIC/NAMIC, page 3-4, 6

Summary: The rate of return selected by the Department was determined, to a large extent, by the data for the relatively small number of very large, national insurers. Such a number is inappropriate for smaller domestic insurers for two reasons. From a financial perspective smaller insurers cannot achieve the benefits of diversification that accrue to larger firms which helps reduce variability which implies a reduction in risk. Secondly, larger insurers have the ability to achieve scale and scope economies that smaller insurers are not able to. The "risk premium" for small size can be as high as 400 to 1000 basis points. The regulation should at least permit a variance that would allow small insurers the ability to demonstrate that they require higher than average returns.

Response: A previous version of the regulations presented in a workshop provided an explicit adjustment of the return based on size, with smaller companies getting a larger return. Several commenters said that such a size adjustment, while possibly appropriate for market returns, was not appropriate for book returns. The regulations do recognize an applicable variance. Section 2644.27(f)(5) allows a company which writes 90% of its direct premium in California and has a mix of business that presents an investment risk different from the risks that are typical of the line ss a whole to request a higher rate of return.

Commenter: Milo Pearson and Christian Rataj, on behalf of the Pacific Association of Domestic Insurance Companies (PADIC) /National Association of Mutual Insurance Companies (NAMIC); September 12, 2006;
David Appel, on behalf of PADIC/NAMIC, page 5

Summary: The maximum permitted after-tax rate of return is 11% without provision for change in the value in the future.

Response: In response to this and similar comments, the Department is proposing amendment of this section.

Commenter: Milo Pearson and Christian Rataj, on behalf of the Pacific Association of Domestic Insurance Companies (PADIC) /National Association of Mutual Insurance Companies (NAMIC); September 12, 2006;
David Appel, on behalf of PADIC/NAMIC, page 5

Summary: The Department cites a Safeco decision as support for the 11% rate of return. That decision was based upon my testimony in that case. If the methodology I employed was updated to include more up-to-date data, the required rate of return would be closer to 13%.

Response: Please see responses to comments elsewhere in this rulemaking file regarding the selection of the maximum rate of return. The studies included in this rulemaking file justify selection of 11% as the maximum permitted rate of return.

Commenter: Milo Pearson and Christian Rataj, on behalf of the Pacific Association of Domestic Insurance Companies (PADIC) /National Association of Mutual Insurance Companies (NAMIC); September 12, 2006;
David Appel, on behalf of PADIC/NAMIC, page 5

Summary: There is an internal inconsistency in the regulations as proposed because the projected yield changes as market yields change but there is no provision for the cost of capital to also reflect the changing market conditions.

Response: In response to this and similar comments, the Department is proposing amendment of this section.

Commenter: Peter M. Cazzolla, President-CEO of CIG, September 12, 2006 page 1-2; Transcript at page 16-17

Summary:: The rate of return restrictions in the prior approval regulations will create a business climate that downplays creativity, incentive and investment, encourages mediocrity and complacency in the development of product and setting of rates, discourage additional capital and coverage capacity and will significantly diminish the financial equity value of domestic property and casualty insurance companies including my own company, which is an ESOP company, causing my employees and my own retirement account values to be diminished.

Response: The 11% rate of return is well within the typical rates of return earned by property-casualty companies, and the predictions set forth in the comment have not resulted from that rate of return.